MEDDD

WAR DEPARTMENT
Office of The Surgeon General
Washington 25, D.C.

6 August 1946

MEMORANDUM FOR

Subject: The Surgeon General's Conference,
18 - 19 July 1946

1. There is transmitted herewith for your information a copy of the report of the conference of The Surgeon General with surgeons of major forces, army surgeons, commanding generals of army medical centers, and Surgeon, Military District of Washington on 18 - 19 July 1946, at The Pentagon, Washington, D. C.

FOR THE SURGEON GENERAL:

GUY B. DENIT
Brigadier General, USA
Chief of Plans and Operations

1 Incl.
Report of Conference

DISTRIBUTION:

2 copies to each conferee
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THE SURGEON GENERAL'S CONFERENCE
Washington, D.C.

18 - 19 July 1946

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Inclosures

THE SURGEON GENERAL'S CONFERENCE
Washington, D. C.

18 - 19 July 1946

The Surgeon General's Conference was convened at 0900 hours, 18 July 1946, in Room 2E 809, the Pentagon, Washington, D. C.. The following were present:

Office of The Surgeon General

Major General Norman T. Kirk, USA
The Surgeon General

Brigadier General Raymond W. Bliss, USA
Deputy Surgeon General

Brigadier General Guy B. Denit, USA
Chief of Plans and Operations

Surgeons of Major Forces

Brigadier General Malcolm C. Grow, USA
Surgeon, Army Air Forces

Colonel Frederick A. Blesse, MC
Surgeon, Army Ground Forces

Commanding Generals of Army Medical Centers

Brigadier General George C. Beach, USA
Commanding General, Army Medical Center, Wash., D. C.

Brigadier General John M. Willis, USA
Commanding General, Brooke Army Medical Center
Fort Sam Houston, Texas

Army Surgeons

Brigadier General Charles M. Walson, USA
Surgeon, First Army

Colonel George W. Rice, MC
Surgeon, Second Army

THE SURGEON GENERAL'S CONFERENCE
Washington, D. C.

12 - 13 July 1950

The Surgeon General's Conference was convened at 0900 hours, 12 July 1950, in room 2E 529, the Pentagon, Washington, D. C. The following were present:

<u>Office of The Surgeon General</u>

Major General Raymond W. Bliss, USA
The Surgeon General

Brigadier General [illegible], USA
Deputy Surgeon General

Brigadier General Guy B. Denit, USA
Chief of Plans and Operations

<u>Surgeons of Major Commands</u>

Brigadier General [illegible], USA
Surgeon, Army Field Forces

Colonel Frederick A. [illegible], MC
Surgeon, [illegible]

<u>Commanding Generals of Army Medical Centers</u>

Brigadier General George C. Beach, USA
Commanding General, Walter Reed Army Medical Center

Brigadier General [illegible], USA
Commanding General, Brooke Army Medical Center
Fort Sam Houston, Texas

<u>Army Surgeons</u>

Brigadier General [illegible], USA
Surgeon, First Army

Colonel George [illegible], MC
Surgeon, Second Army

[illegible]

Colonel Robert P. Williams, MC
Surgeon, Fourth Army

Colonel John A. Rogers, MC
Surgeon, Fifth Army

Brigadier General William A. Hagins, USA
Surgeon, Sixth Army

Brigadier General James E. Baylis, USA
Surgeon, Seventh Army

Surgeon, Military District of Washington

Colonel Robert H. Lowry

A. WELCOMING ADDRESS.....Major General Norman T. Kirk

General Kirk opened the conference by welcoming the conferees and explaining the reasons for having the conference. Because of the reorganization of the War Department in which the nine (9) service commands were superseded by six (6) army areas, new problems in personnel and administration were created.

General Kirk explained that since the mission of the Medical Department is the prevention of disease and care of the sick, it is important that The Surgeon General know the problems of the Army surgeons, so that they can be assisted in the carrying out of their mission.

General Kirk pointed out that most of the work of the Army surgeons will be direct with the War Department in matters concerning service functions in Army areas and with Army Ground Forces in matters pertaining to the training of medical units normally assigned to an Army. Radios emanating from the War Department directed that the army surgeons act for The Surgeon General from a technical standpoint, that they assist general hospitals and give The Surgeon General information concerning technical matters. General Kirk also brought out the point that army surgeons are responsible for the care of the sick in Class I medical installations.

Consultants in surgery and internal medicine are available to assist army surgeons in the care of patients. It is hoped that these consultants will be utilized to the fullest and that the army surgeons will give them full support. These consultants can be used in Class I, Class II and Class III medical installations. They can help to improve medical service at Class II hospitals and can also assist in training, until the Army has sufficient men to carry out its training. Professional personnel must be qualified to meet the requirements of the American Board. General Kirk brought out two (2) important points in this respect: (1) medical officers must be trained to give patient care and (2) to pass boards.

It will be the responsibility of commanding officers of Class II installations to get key civilian workers. It is a well-known fact that the great number of Medical Department specialists we had during the war have now been separated from the service. There is a critical shortage of Medical Department specialists to do the job. To alleviate this situation there are approximately 1200 ASTP graduates undergoing basic military training at Brooke Army Medical Center. These officers, upon completion of training, will be utilized as overseas replacements or assigned to zone of interior medical installations and units.

At present the strength of the Medical Corps is 1136 officers. One hundred and ninety-seven officers have been lost since VE-Day, and less than 197 have been integrated since that date in the Medical Corps. What is being done about trying to recruit additional officers; about nurses for peacetime service? Attempts have been made to get legislation through since last November. There are three (3) bills pending and the Army Nurse Corps bill cambe back from the Bureau of the Budget today for reconsideration of certain provisions. It is the general concensus of opinion among medical observers that nurses ought to be retired at the age of 50 years, instead of after 30 years service. That is where the noncurrence came in -- the Bureau of the Budget figures that every officer should do 30 years of service. The question as to what grade nurses should be retired in was brought out. General Kirk thinks too many are being retired in the grade of captain instead of colonel.

The promotion bill for Medical Corps officers has been held up along with the promotion bill for the whole Army. The Chief of Staff has been notified that something must be done to recruit doctors and it was agreed that the bill would go to Congress for Medical Department only. The Surgeon General commented on the various provisions of the bill, such as specialist pay, time in grade, etc.

The Medical Service Corps bill is written to take in auxiliary people to assist the Medical Corps, such as: sanitary engineers, entomologists, bacteriologists, pharmacists, optometrists, social workers, and others. These officers are to be promoted through grade of lieutenant colonel and colonel in a manner similar to that of non-promotion list officers.

Pharmacists, Sanitary Corps officers, optometrists want to have their own corps. A common service corps, called the Medical Service Corps, has been proposed for these various groups. This corps will be comprised of professional as well as administrative officers, and will include all officers formerly commissioned in the Medical Administrative Corps, the Pharmacy Corps, and the Sanitary Corps. Congress may not pass this bill, but the Medical Department is going to give it every possible support. Those are some of the plans this office has been working on since last November for the peacetime Army. In the promotion bill for the whole Army, as written, the retirement age for all officers will be sixty years - the same as for line officers. That will go up before the next Congress.

General Kirk expressed the hope that some of the problems of the reorganization will be solved at this conference.

B. STATEMENT OF CONFERENCE AIMS...Brigadier General Guy B. Denit

Brigadier General Denit extended his welcome to the army surgeons and stated that the conference was called for the purpose of discussing the many problems that confront each of them and the Medical Department as a whole. He brought out that the surgeons for the air forces, ground forces, and the six (6) armies have new functions and responsibilities under the reorganization of the Army as set forth in War Department Circular 138, current series, and that The Surgeon General has the overall responsibility of supervising the medical service in all echelons of command and has command responsibilities for all Class II medical installations. The Surgeon General needs the advice and assistance of the surgeons of all commands and in turn expects to give to them, in the discharge of their duties, all the assistance within the power of his office.

He brought out that the provisions of War Department Circular 138 are tentative and stated further that there are certain pertinent questions concerning these provisions which should be considered and answered at this conference. Are the provisions satisfactory to the Medical Department? Do they tie the hands of The Surgeon General unnecessarily? Are the staff relationships and the channels of communication satisfactory? What changes should we, of the Medical Department, request in order to more efficiently discharge our functions when our comments and recommendations are submitted to the War Department? General Denit said he realized there were many problems which had confronted the Army surgeons in their new positions, such as, a suitable organization for their offices, their staff relationships and their dual functions as army surgeons and surgeons for army areas. He mentioned that The Surgeon General was likewise confronted early in the reorganization with the vital matter of having someone represent him in each army area to assist him in the supervision of the professional care of patients in his Class II hospitals and to carry out his consultant program. He said that for the time being, at least, War Department instructions permit The Surgeon General to request of the army surgeons, assistance in this vital matter, but that this subject was on the agenda for discussion.

He stated that in their dual capacities, the army commanders have certain functions which require dealing with the War Department direct, others with the Army Ground Forces, others with the Army Air Forces, and still others with the chiefs of services of the War Department. A complete understanding as to where these responsibilities begin and end is vital to everyone in the discharge of their duties. Thus, the Air Surgeon and the Ground Surgeon have been invited to attend the conference to give their understanding on these vital relationships.

General Denit said that hospitalization means care of the sick. Army hospitalization should be the best the world can afford. The Surgeon General wants it to be that way, not only from the standpoint of the professional care of the patient, but also from the standpoint of the well-being of the patient and his physical comfort. He said that hospitalization would be discussed in the light of the installation, the use of the specialist and the consultant and the overall planning for postwar needs. He reminded the conferees that the matter of personnel was ever at hand and was one of the most pressing problems. He stated further that something must be done at once to interest desirable candidates to apply for commission in the Regular Army and that the corps must be built up to the desired standards at the earliest possible moment. General Denit was of the opinion that in order to do this, it would be necessary to have a good legislative program and the enthusiastic backing of the civilian profession. Contacts must be gained and maintained with civilian medical societies and medical schools. He stated that it is important to have a Medical ROTC program at the earliest date and that an intensive campaign to win the good will of the ASTP graduates must be started and efforts made to make their present tour of duty in the Army sufficiently attractive to interest them in applying for the Regular Army. This would mean telling them of the pending legislative program and of the plan for professional graduate training which it is hoped will raise the standard of medical care in the Army to the highest level. General Denit mentioned that other vital problems which were on the agenda for discussion were the preventive medicine program and the supply program and he also invited the conferees to bring up their own subjects for discussion if they desired.

General Denit stated that the tremendous task of adjustment to the economies and restrictions imposed by postwar conditions confronts us, that the resources in trained personnel to accomplish the tasks ahead are at a low ebb. He emphasized that it would be necessary to utilize the existing talent to the highest degree of efficiency and avoid misunderstanding of duties and responsibilities--most of all duplication of effort.

He said that he felt that a meeting of the minds in an informal conference such as this would pave the way to the accomplishment of that end.

C. THE ARMY AIR FORCES UNDER THE WAR DEPARTMENT REORGANIZATION PLAN.....Brigadier General Malcolm C. Grow

General Grow, Air Surgeon, Army Air Forces, presented his views concerning the relationship between the medical service of the Army Ground Forces and the Army Air Forces. He stated that War Department Circulars 138, 151 and 170 for 1946, together with the Simpson Plan and the Hodes Memorandum have been and are continuing to be under study in his office. He stated that his office agrees that the Army Air Forces will continue to operate station hospitals and dispensaries together with the School of Aviation Medicine and the Aero Medical Research Unit at Wright Field. Within the zone of interior the air forces proposes to operate a considerable number of small widely dispersed bases rather than to concentrate large numbers of personnel and material into a few major installations. Consequently, no requirements will exist for large station hospitals while dispensaries alone will suffice for the medical attendance at many of the bases. It was his desire that professional consideration not be entirely subordinated to tactical ones and in this connection he proposes to maintain sufficient professional skill at a number of their larger hospitals to provide thorough-going periodic medical surveys of flying personnel in keeping with the care-of-flyer program which is so vital as a guarantee of efficient operation through the conservation of flying personnel. It was hoped that the medical attendance at these stations might be of such a variety and magnitude that the basic services there, that is, medicine, surgery, eye, ear, nose and throat and possibly neuropsychiatry may merit approval by The Surgeon General for professional training. While the air force has no intention of competing with general hospitals in the matter of definitive medical attendance it is desirable that a high level of professional "know-how" and experience be maintained in a number of their installations against the possibility that the autonomous air force may become a reality. The Air Surgeon also believes that the medical service of the air forces would benefit from the free employment of the civilian consultants maintained by the army surgeons. With respect to training programs it appears that the air forces will be responsible only for the operation of the School of Aviation Medicine. It is now proposed that basic and advanced courses for aviation medical examiners and flight surgeons be taught in addition to the course for flight nurses and certain enlisted specialists. While air force medical officers are anxious to avail themselves of the professional training opportunities which may be extended to them as a corollary of rotation through the Class II medical installations, General Grow feels that certain of the air force personnel have been long identified with the air forces, and consider aviation medicine as their specialty. These officers would prefer to remain with the old establishment and he did not believe that these individuals could be rotated advantageously from the air establishment. He stated that he would like to describe the action which the air forces have initiated in keeping with the policy of The Surgeon General for the conservation of Medical Department personnel.

Upon the cessation of hostilities it became apparent that no justification continued to exist for the employment of Medical Department personnel for whom a requirement had formerly existed of such magnitude as would provide sufficient numbers of the professional categories to meet such contingencies as unanticipated personnel casualties resulting from enemy action, the sudden outbreak of large epidemics attributable to familiar or previously unknown disease entities and the introduction of chemical or biological warfare by the enemy. Medical installations and tactical units which had heretofore been, in many instances, manned with medical officers against such emergencies, much as firemen in fire departments, were now rapidly becoming excess to the needs of the Army in peacetime. Accordingly, manning tables at zone of interior medical facilities within the Army Air Forces were scrutinized and bed authorizations were closely correlated with occupancy rates. As the hospitalization load diminished bed credits were cut in successive decrements which necessitated a simultaneous reduction of the manning tables for these installations. The policy for the conservation of Medical Department personnel was also applied to the overseas theaters in the following manner: Radiograms were directed to the major overseas commands on 12 October 1945 inviting concurrence in a proposed plan which would reduce the authorizations for medical officers in AAF combat and service groups, from the normal figure of one (1) officer per group headquarters and one (1) officer per squadron; to two (2) officers per combat group and one (1) officer per integrated service group. This action which was to be effected through the elimination of a number of squadron medical sections from each group, would concurrently dictate a saving in Medical Department enlisted men. Preliminary replies from air force surgeons in overseas theaters indicated a general concurrence in the policy outlined here but in some instances air force surgeons indicated that the proposed policy of personnel economy would, if generally applied, strip their medical service to a bare subsistance level. In view of the public demand for the separation of medical officers, dentists, and nurses, it seemed advisable to implement the proposed reduction in the manning authorizations for tactical units overseas, despite the recommendations of the overseas air force surgeons, who cautioned against haste in the application of this policy. Accordingly on 1 November 1945 the theater commanders in the Pacific, Europe, the Caribbean Defense Command, and of the strategic air forces were directed to relieve from assignment all Medical Department personnel from tactical groups in excess of the personnel authorized in the group medical section plus one (1) squadron medical section. It is believed that the wisdom of this policy was confirmed in subsequent War Department action which established Medical Corps, Dental Corps, and Army Nurse Corps ceilings in the overseas theaters based upon hospital bed authorizations and troop strength. Insofar as this policy applied to the air forces overseas, the reductions effected were approximately equivalent to the reductions already

directed in the case of air force tactical units by Headquarters, AAF, on 1 November 1945. This conservation policy was simultaneously applied to the zone of interior tactical units on 25 October 1945 when the major AAF commands were directed to delete the manning authorizations for the medical sections of all the component squadrons of tactical groups. Further directions that group and separate squadron surgeons remaining in tactical units would be attached to the base medical facilities for duty in the hospital were also issued.

At the present time it seems desirable that all Medical Department personnel be relieved from assignment to tactical units in the zone of interior for reassignment to the base medical installation. This action is dictated by the following considerations: First, because better economies in the utilization of Medical Department personnel can be exercised through the pooling of all medical resources under the command jurisdiction of the base surgeon. Second, in general, matters pertaining to aviation medicine may be more easily processed through the office of the base flight surgeon rather than through an individual tactical unit flight surgeon. The personnel relieved from tactical unit duties will become available for professional duties in AAF station hospitals. Meanwhile the base flight surgeon will attach such Medical Department personnel as may be required to tactical units deployed upon maneuvers, or in transit, or whenever such medical attendance is indicated.

The application of this policy will effect a considerable, but not a wholesale, economy in the utilization of Medical Department officer personnel because the number of tactical units stationed within the zone of interior is not large; however, this action will reduce the Medical Department manning of the domestic component of the AAF to the minimum compatible with efficient medical care.

General Grow then discussed medical statistics or "biometrics" as the air forces call them.

In recent years it has been realized to a greater degree the importance of medical records as a means of assuring more efficient medical care of the mass of Army personnel. General Grow used the term "medical records" synonomously with the collection, presentation, analysis and interpretation of numerical data. Through a study of medical records there is found numerical expression of labors which point out fields for investigation and research. The air forces is particularly interested in two (2) distinct phases of medical record administration: namely (1) the processing of general health records from AAF stations in order that they may remain cognizant of health conditions and (2) the analysis of records pertaining to the individual and the application of this knowledge to the mass. General Grow felt that medical records have not been utilized to the utmost advantage.

The war produced some changes in the administration of medical records which made more efficient handling possible. He gave the following discussion on the processing of general health records from AAF stations to facilitate comprehension of health conditions at those stations.

During the war a policy was established which required the transmission of the Statistical Health Report and the Report of Sick and Wounded, from stations in the field, to The Surgeon General. Courtesy copies of these reports were transmitted to various agencies and a copy went to the Office of the Air Surgeon. This method of transmission of records represented an improvement upon the old technical channel, as by this means all agencies concerned became aware of the current health situation at approximately the same time. One (1) headquarters (in this case the Office of The Surgeon General) was charged with the correction of errors which, in itself, produced standardized reporting and consistency of administration. The Air Surgeon utilized copies of reports so received to determine the health of the air forces, to compare noneffective rates among the several major commands and to study the evolution and propogation of certain diseases within the air forces. At the same time copies of these records from AAF stations were transmitted to air force commands and to the appropriate service command.

The recently announced reorganization of the Army caused some retrenchment of thought. It seems that two (2) distinct policies have been established in the case of medical matters. With regard to record administration it was and would be difficult to use command channels exclusively for the transmittal of medical reports upward from air force stations and yet expect The Surgeon General to fulfill his function of policy making and inspectional duties. With this discrepancy in mind representatives of the Office of the Air Surgeon met with representatives of the Office of The Surgeon General to work out a procedure whereby the air forces would receive the required information relevant to the health of AAF personnel and, at the same time, satisfy the requirements of The Surgeon General. The solution, which is being published in new Army Regulations consists mainly in maintaining the status quo, with copies of AAF medical reports from the station level continuing to be forwarded direct to interested parties; the original to The Surgeon General, and courtesy copies to the air surgeon of air force commands and army surgeons. In addition, changes in reporting procedures will make information on AAF personnel hospitalized in non-AAF hospitals available to the Air Surgeon thus facilitating completeness of reporting.

As far as the Report of Sick and Wounded is concerned, it is believed that the present policy is to continue transmission direct to The Surgeon General. Other changes will make available to the Air

Surgeon "copies" of the Individual Medical Record Card on AAF personnel, wherever they may be treated and disposed of.

The second use of medical records is "the analysis of individual records and the application of the knowledge gained to the mass." When the above-mentioned directives come into force the Report of Sick and Wounded can be used by his office for these studies. In addition there exist two (2) medical records concerning flying personnel: the Care of Flyer Report and Flight Surgeons Report of Aircraft Accident. Although these records are compiled upon a selected group of individuals within the air force, as far as the Office of the Air Surgeon is concerned, flying personnel are actually the nucleus of the air force. They constitute a special group of highly selected men within the greater body of the air force establishment. During the war when standards were at their lowest, the air force was only able to "graduate" as flying personnel 9% of men applying for and desiring flying training. This small figure resulted from the application of rigid physical and mental examinations, and from the demands of the highly specialized field in which these men found themselves. Although the tendency in the modern world is to equalize all men; it can only be concluded that upon the basis of cost to the government, the difficulty of obtaining men qualified to become flying personnel and the special psychological and technological considerations applying in the case of the flyer, these personnel are of more value to the military service and to the waging of successful war than non-flying personnel within the air forces. For these reasons considerable emphasis is placed on studies of the records of these men in their attempts to find better selection methods, maintain the peak of flying proficiency, determine the effects of disease on flying proficiency, evaluate the physical conditions of flight which affect these men together with the special types of injuries sustained by these men in aircraft accidents and the factors underlying these accidents. All these efforts to improve their knowledge of aviation medicine, in addition to the more practical consideration of keeping these men fit for flying duty, have their basis in these reports on flying personnel required by the Office of the Air Surgeon. To illustrate, from studies of detailed reports of this type the causes of frostbite sustained by combat crews have been determined and from this knowledge active means of combatting this disorder have been applied. These detailed reports were used on combat flying personnel to determine the body areas most susceptible to wounds and to study approximate velocity of the muscles involved from which knowledge the idea for protective body armor was born. During these peacetime years there are still many problems yet unsolved. These include aero-otitis media, and the effects of extremely high altitudes on the body; furthermore as supersonic aircraft are developed new magnitudes of speed and acceleration must be faced. Hence, detailed studies of conditions. affecting flyers are continuously indicated.

Although reports on flying personnel are of little value to other than AAF medical personnel they were emphasized here because of their statistical relationship to medical data applicable to other categories and to acquaint The Surgeon General with what the Air Surgeon is doing with the records he receives on flying personnel. With regard to medical reports and records on flying personnel no radical changes in channels or administration are contemplated but these reports continue to be received in the Office of the Air Surgeon - courtesy copies going to interested headquarters of lower echelons.

D. THE ARMY GROUND FORCES UNDER THE WAR DEPARTMENT REORGANIZATION PLAN.....Colonel Frederick A. Blesse

Colonel Blesse, MC, Surgeon, Army Ground Forces, was called upon to express his views in regard to the reorganization as it effected the Army Ground Forces Medical Section.

Colonel Blesse stated that it was realized by the War Department that many of the changes involved in this reorganization would present real problems for the army staff but, since the various army staffs contain highly qualified officers experienced in solving staff problems, such problems would be solved or constructive criticism presented to improve the procedures outlined. He stated that comments and recommendations of changes should be prepared, carefully analyzed and coordinated before transmittal by the armies to the Director of Organization and Training prior to September 1.

Colonel Blesse then commented on the status of Medical Department personnel. The overall picture of Medical Department personnel available for assignment to general reserve units has materially improved in the past month. Two (2) main sources for Medical Department personnel at present are: (1) officers who have recently been integrated into the Regular Army, a number of which are being made available for assignment to general reserve units and (2) ASTP's who have become available for duty upon graduating from Field Service School at Brooke Army Medical Center. Their headquarters has taken advantage of these sources of personnel and assigned sufficient Medical Corps personnel to fill all known vacancies and vacancies projected through 1 July as a result of change in discharge criteria effective 1 July 1946. Officers, in some instances, may exceed personnel authorizations, but future losses were taken into consideration in making these assignments and it was felt that in the case of the ASTP's it was advisable to make assignments prior to the loss of experienced officers in order that these new officers might be oriented. A shortage of MAC officers exists but at the present time an increasing number of these officers is being made available for assignment to Army Ground Forces units—the majority of these officers having recently been integrated into the Regular Army. Under provisions of the directive establishing a Central Officers' Assignment Group, an agency under the direction of the War Department, all officers assignment both within the zone of interior and overseas will be made thru this group with certain key positions being referred to the Ground Medical Section for recommendation.

With reference to training, it has been decided that the basic school for newly commissioned officers will consist of two (2) parts: a Branch Immaterial Course and a Branch Material Course. All officers

regardless of army or service will attend the Branch Immaterial Course, which will be conducted by the Replacement and School Command under the direction of Army Ground Forces. The Branch Material Course will follow immediately at the Army or Service School. This year the Branch Immaterial Course will be given at Fort Knox, Fort Sill and Fort Benning. There will be no medical officers in this course. In 1947, however, the course will be given at Fort Riley, Kansas, and medical officers will participate. The majority of officers attending this Branch Immaterial Course will be graduates of the Military Academy or men who have had ROTC training. The bulk of Army Ground Forces medical officers, however, will not have had military training at the time they receive their initial commissions. It has, therefore, been recommended that medical officers report for the Branch Immaterial School one (1) month in advance of the beginning of the course. This month would be devoted to training in basic subjects such as drill, customs and courtesies of the service, map reading, etc. It is believed that after this month of indoctrination they will be better able to understand the Branch Immaterial Course. At the completion of the course at Riley, our officers will proceed to the Brooke Army Medical Center for the Branch Material Course, which is scheduled to be of five (5) months' duration. A common Officer Candidate School is also being established for all arms and services. This is in keeping with General Devers' policy that the barriers between the various branches of the service be reduced and that comradeship and mutual understanding be developed early in young officers. Army Ground Forces continues to operate various special schools and the schools of the arms. These include the Antiaircraft School, Ft. Bliss, Texas; the Field Artillery School, Fort Sill, Oklahoma; and the Air Training School, the Infantry School and the Airborne School at Fort Benning Georgia; the Cavalry School at Fort Riley, Kansas; the Coast Artillery School, Fort Winfield Scott, California; the Mountain and Winter Warfare School at Camp Carson, Colorado, and the Armored School at Fort Knox, Kentucky. In addition, the various Replacement Training Centers are operated by Army Ground Forces. Proper emphasis on medical training is being given in all of these schools and also in the Replacement Training Centers.

Colonel Blesse brought out the importance of medical participation in winter exercises which the Army Ground Forces have scheduled for 1946 and 1947, where physiological effects of cold, nutritional aspects of survival in cold weather and the effect of cold on equipment will be studied.

He stated that training programs have been published for units of the National Guard and similar programs are in the process of preparation for units of the Organized Reserves. Army Ground Forces

has the overall responsibility for the training of those units, but those service units not normally assigned to a field army will be the responsibility of the chiefs of the respective technical services. It is of the utmost importance that the lessons learned in the recent war should not be forgotten as they will greatly benefit our future planning. The cooperation of all is needed in the selection of proper personnel to conduct and participate in this training and to inspect training activities frequently to see that active, progressive and realistic training is being conducted.

The Medical Test Section, Army Ground Forces Board No. 2, has been established to meet two (2) essential requirements of the Army Ground Forces: (1) to provide an agency to field test medical equipment and supplies used by Army Ground Force medical units and (2) to provide an agency to field test, from a medical (physiological) aspect, equipment and supplies to be used by the combat arms and services of Army Ground Forces. Monthly progress reports and a final report of service testing will be submitted on each item according to the form prescribed by the Commanding General, Army Ground Forces Board No. 2. The reports will be distributed by Headquarters, Army Ground Forces, to interested agencies of the Army, Navy and Air Corps.

Army Ground Forces is anxious to receive the recommendations of the army surgeons and in the case of suggested changes in T/O & E's to be of the greatest value they should be submitted through command channels.

E. ORGANIZATION OF ARMY SURGEON'S OFFICE AND RELATIONSHIP OF ARMY SURGEONS TO ARMY COMMANDERS IN THEIR DUAL CAPACITIES AS ARMY SURGEONS AND ARMY AREA SURGEONS...
.....Brigadier General Guy B. Denit
Colonel Frederick A. Blesse
Brigadier General Chas. M. Walson
and Army Surgeons

Brigadier General Guy B. Denit called upon Brigadier General Charles M. Walson, First Army Surgeon, to open the discussion of the organization of the army surgeon's office and the relationship of army surgeons to army commanders in their dual capacities as army surgeons and army area surgeons.

General Walson made the following statements: Prior to World War II the corps area surgeon's functional chart was practically the same in each corps area. With the advent of service commands there has been a great variation in functional charts and the personnel authorized for service commands throughout the Army. Headings were designated divisions, branches or sections and various nomenclatures for headings were used. The titles of positions were not uniform. In one service command the chief medical officer was designated the medical director rather than the surgeon. Some organization charts did not show a personnel division, branch or section. In fact, as you all know, the service command regulations did not provide for a personnel division under the surgeon. Fortunately, most of us were able to convince our commanding generals that we could not function without a personnel division. Personnel struggles, incidentally, has been our nightmare during this war. So much interference along this line seems so unnecessary. In the future, I do hope there will be no question about the essentiality of the Medical Department procuring, training and assigning all Medical Department personnel. Furthermore, I hope in the next war there is nothing said about one yardstick applicable for all hospitals. I think it is now pretty well recognized that the same yardstick cannot be used for all zone of interior hospitals.

Following World War I the best brains in our Army brought forth the National Defense Act. As a result a command and staff procedure was established based primarily on the results of our experience in World War I. The Regular Army, National Guard and Organized Reserves were indoctrinated in this command and staff procedure through daily usage, and this procedure was taught at schools and summer camps. This system was continued in the early part of World War II and many civilians entering the Army were taught to use this command and staff procedure in World War II. Suddenly, without previous training and preparation the ASF came into being and a new command and staff procedure was promulgated.

Many of us, knowing the old adage "Never change horses in the middle of a stream" felt this change was a mistake.

Recently, ASF terminated and the army area organization came into being. In a great measure the pendulum has swung back to our former command and staff procedure. As a whole, I believe the new organization is an improvement. However, there is one factor in the present organization directive (WD Circular 138 c.s.) which, to my mind, is a cause for grave concern. I refer to the fact that the General Staff: G-1, 2, 3 and 4, becomes an operative agency. Heretofore, stress was always placed on the inadvisability of the G's being operative agencies. Their function was solely advisory or supervisory. While this has not caused the surgeon of the First Army any embarrassment so far, nevertheless, as regulations now exist, it could be a troublesome factor and the success of staff procedure should not have to depend upon personalities.

You will observe that the chart presented here shows some variations from what has been used as an organization chart by many service commands heretofore. I have included a deputy surgeon. The main departments are called divisions and activities stemming from divisions are called branches and some of these branches are broken down into sections. I have always kept the preventive medicine division separated from the hospitalization, evacuation, and professional divisions. Overseas, I appreciate that hospitalization and evacuation were carried under the operations division. You will note I have placed operations with plans and training division. There are many reasons for doing this. There has been a tendency by War Department to divorce training from the surgeon's office; instead to detail a medical officer with the director of military training at service command headquarters. I think by consolidating the operations, training and plans in one division these activities can be held where they rightfully belong under the army surgeon. There is no reason why the operations, plans, and training division cannot continue so much of operations as is indicated. Furthermore, during summer maneuvers the operations, plans and training division could go into the field, leaving behind the hospitalization evacuation and professional divisions, and thereby not interfere with the normal functioning of the army surgeon's office at the army base headquarters.

I strongly believe that we should insist on a Medical Department personnel division. For that reason the complete breakdown is shown under this heading.

I don't see why we cannot use the term "army surgeon" rather than "chief medical officer" providing it is clearly understood by the army commander that The Surgeon General will continue to call upon the army surgeon for necessary assistance and technical supervision

over all Class II installations within the geographical limits of the area. Directives should be issued by the War Department authoring direct communciation between commanders of medical installations, the army surgeon, and The Surgeon General. This seems essential for The Surgeon General to obtain the maximum utilization of the Medical Department serving troops within the area.

There are within the First Army Area 152 installations, exclusive of 175 sub-stations; 102 are Class I installations directly under the Army Commander. In 38 Class II installations within the First Army Area, the First Army is responsible for all Medical Department activities. In other Class II installations (general hospitals) we exercise technical staff supervision for The Surgeon General in conformity with War Department directives, to assure maximum possible utilization of the medical means available. Twelve (12) are Class III installations directly under the Army Air Forces. Under the present War Department organization of Class I, II and III installations, it seems essential that The Surgeon General should have a representative at army area geographical level to look after Medical Department activities therein. Our well-rounded staff of specialists can just as well perform their special work at installations not directly under the army commander. This will result in economy of personnel and prevent duplication of effort, aside from rendering much assistance to The Surgeon General's staff and, directly, all Class II and III installations.

I believe the organization and functional charts pertaining to the Surgeon's activities for each army area should have the concurrence of The Surgeon General. It is very evident that certain divisions of the army surgeon's office in some areas should be more heavily staffed than in others. This is contingent on the activities, population census, etc.

More than 26% of the physicians in the United States reside in the First Army Area. Therefore, many activities including National Guard, Organized Reserve, and ROTC work would be greater in the First Army Area than in other army areas.

Personnel shown in charts are based on the limitations prescribed by the First Army Commander.

If all army surgeons jointly agree on the medical organization, personnel, specialties and specific duties required for an army, giving complete justification for each individual necessary in an army surgeon's office, and The Surgeon General approves what we consider our essential needs, there should be no difficulty in obtaining our requirements.

The Medical Department must go forward, or it will go backward; we cannot stay in "status quo". Modern medicine demands a well-rounded staff to supervise all phases of medical activities. Medical activities in each army area justify the full time of a complete staff. All Class I, II and III installations should avail themselves of the army surgeon's staff. Triplicate organizations to serve each class installation cannot be justified.

The Medical Department of the Army has an enviable record. We have made mistakes; occasionally incidences have occured where personal ambitions took priority over the interest and needs of the Medical Department. Bickerings, jealousies and friction to the detriment of the Medical Department as a whole are unpardonable.

Recently, representing the Commanding General, Second Service Command, I attended a luncheon given by the Transportation Corps. At this meeting a prominent transportation officer stated to me: "The Medical Department made great strides in World War I by their teamwork, pulling together and from the support of the medical profession especially through the backing of the American Medical Association. In this war the engineers took the cue and cultivated the good will of the American Society of Civil Engineers. Profiting from the experience of the Medical Department and Engineer Corps, we have organized the 'Army Transportation Association'. This is a national organization and now there are about 40 chapters. We hope it will be our Santa Claus in the future. We expect to have frequent meetings. We encourage all officers, enlisted personnel and civilians to become members of our association. Among our membership are presidents of railroads and other prominent transportation specialists."

The Medical Department has a challenge; we cannot stand still - it is either backward or forward. We must stimulate the younger men to carry the banner as crusaders with vigor, force, enthusiasm, loyalty and fervent religious devotion for our exalted Medical Department, U. S. profession.

My convictions are that The Surgeon General's achievements are phenomenal in this war in spite of many handicaps. Numerous instances could be cited. Far-reaching vision concerning the management and planning for special types of hospital cases in special hospitals and concentrating specialists therein accordingly, I believe, did more than any other one thing to prevent severe criticism of the Medical Department in the last stages of this war.

The surgeon of each army was called upon to discuss, in detail, the present organization and functions of his particular

office. A general discussion followed in which it was decided that a basic organizational structure should be adopted which would insure uniformity of organization of the offices of the surgeons in the six (6) army areas. The attached chart (inclosure No. 1) shows the basic organizational structure agreed upon.

F. COORDINATION BETWEEN THE SURGEON GENERAL AND ARMY SURGEONS OF PROFESSIONAL ACTIVITIES IN CLASS II MEDICAL INSTALLATIONS.. Brigadier General Guy B. Denit

General Denit was asked to explain the responsibilities of the army surgeon in connection with general hospitals as autherized in a TWX stating that army surgeons would assist The Surgeon General in overall supervision of the care of patients in Class II installations. General Denit explained that other technical services had area or district representatives, but that The Surgeon General did not have sufficient qualified personnel to establish such offices, and that it was felt the country was too large for proper supervision to be exercised by this office without some local representation. Therefore, the army surgeons had been asked to represent The Surgeon General to see that a complete program of medical and professional care is carried out. In carrying out this responsibility, the army surgeon would use his professional consultants not only at installations under the army command but at Class II medical installations as well. General Denit stated that the TWX gave authority to the army surgeons to inspect general hospitals within their area and report on such inspections to this office. General Kirk asked the army surgeons, specifically, to assist the commanding officers of the Class II hospitals in obtaining personnel (Engineer, Quartermaster, etc.) which is supplied by the army.

A general discussion was held on the responsibilities of the army surgeons under WD Circular 138, War Department reorganization. General Baylis stated that the responsibility of the army surgeon at Class III installations is not covered in the circular and needs clarification. Specific questions were brought up concerning inspection of meat at the source for Class III installations, auditing of hospital funds for Army Air Forces stations, inspection of laboratories, and consultation service. None of these subjects is covered in Circular 138 but it does provide that the Army shall continue to perform any function formerly carried out by the service command that is not specifically mentioned in the circular. Colonel Cook (Air Surgeon's representative) stated that the inspection of meat at the source is now done by army veterinarians for Class III installations. General Denit stated that inspections at Class III installations should be done on individual request for such inspections. Colonel Cook requested that inspection reports of Class III activities by army area representatives be routed through the installation to the Air Surgeon's Office. General Denit requested the army surgeons and medical center commanders to submit any recommendations they have for changes in WD Circular 138.

G. ARMY HOSPITALIZATION - ADMINISTRATIVE AND OPERATIONAL PROBLEMS: ..... Lt. Colonel James T. McGibony
Colonel William F. Cook
Officers and Civilians

1. Review of hospitalization program. -

Lt. Colonel James T. McGibony, MC, Chief, Hospital Division, SGO, reviewed briefly the patient load in zone of interior hospitals at peak and at present with the gradual decrease in the general-convalescent hospital system. At the present time there are approximately 73,000 patients in zone of interior hospitals and of that number about 28,000 are evacuees from overseas. AAF hospitals have approximately 5,000 patients. In general hospitals alone there are 49,000 and in convalescent hospitals 3,500. The regional hospital load is about 12,500 and station hospitals around 8,000. There are some 6,000 non-Army patients. The percentage of zone of interior troops in general and convalescent hospitals is running 2.1 and in regional and station hospitals 1.7. Colonel McGibony illustrated with slides and charts the trend in patient loads in the various types of hospitals. A total of sixty-one (61) general and convalescent hospitals have been closed. The hospitals have been turned over to the Veterans Administration, the state or community, or whoever was interested in taking them over.

Of a total of 378,000 German prisoners of war in this country during the war, all but about 10,000 have been sent back. The repatriation included 30,000 patients. Of 51,000 Italian prisoners repatriated, 2,000 were patients, and 700 of a total of 5,000 Jap prisoners were patients.

For evacuation purposes the Army had twenty-seven (27) hospital ships which have now been reduced to six (6). Hospital trains, formerly consisting of 320 ward cars and sixty (60) kitchen cars, have now dropped to 100 unit cars and eighteen (18) kitchen cars.

It is estimated that by September our patient load will be down to 44,000 and the best guess for December is some 33,000. This figure is subject to much variation due to the question of closure of Bruns and Moore, the TB hospitals. These could be closed now if the Veterans Administration could take the TB load.

General Kirk has stated that he wants to eliminate the regional hospitals. At the present time it is planned that by 30 September to do away with all regional hospitals and return to the prewar general and station hospital system. Certain station hospitals, due to geographical location or other circumstances, may

be better staffed than other station hospitals, upon recommendation of the army surgeon. However, General Kirk is anxious that regional hospital type cases be moved to general hospitals. At the present time we have less than 2,000 regional hospital type cases and these could be absorbed into the general hospitals but it would throw an excessive load on the general hospitals, so 30 September has been set for the closure, with retiring boards to continue for 30 days thereafter.

There was a general discussion of treatment of Veterans Administration patients in army hospitals. Colonel McGibony explained that the allocation of beds to the Veterans Administration should be added to the bed capacity of the hospital in requistioning personnel.

2. Hospitalization at Class III installations. -

Colonel William F. Cook, MC, Chief of Plans and Operations, Office of the Air Surgeon, explained that the AAF is presently organized under seven (7) major commands, five (5) of which interlace throughout the United States. Headquarters may be on one (1) coast but all have stations throughout the United States so that coverage is particularly difficult.

In 1944 under over-all supervision of The Surgeon General, the AAF operated some 214 zone of interior installations with an authorized bed capacity of 54,000. Demobilization since VJ-Day has reduced this to 105 installations. It is intended by the Air Staff to maintain these 105 permanently. However, out of the 105, only eighty-five (85) need medical service at the present time. Activities are too low at others. The AAF at present has 9,000 hospital beds authorized and 5,000 patients or about 60% of the beds occupied. The project program closely follows the troop basis as modified by geographical dispersion. Projected troop basis is around 400,000 but that varies. Forty per cent (40%) will be overseas so hospitalization will not have to be provided for them. The remaining 60% or 240,000 which are in the United States will be dispersed to the 105 stations. There will be few stations equal to the Army's one (1) and two (2) division posts. The largest AAF installations will be Scott Field with some 17,000 troops, and Kessler Field next with from 11,000 to 16,000 troops.

In order to facilitate medical planning, it was necessary to break down these installations into four (4) rough groups. Thirty-five (35) are termed "plane storage bases" and "depots" of various types which rate no Army medical personnel whatsoever. They are staffed by fifteen (15) to twenty (20) military personnel and the remainder civilians. These will probably be served by civilian dispensaries. There are twenty-two (22) bases with relatively small

garrisons of less than 500 individuals which will be furnished medical service by 3 to 10-bed dispensaries. Twenty-five (25) stations with strength up to 3,000 will have station hospitals of twenty-five (25) to seventy-five (75) beds. There will be twenty-three (23) bases of sufficient size to justify hospitals of 100 to 500 beds, mostly in the 100 to 250-bed category. The total projected bed authorization at station level is projected as some 7,500 beds.

There are several difficult factors in connection with AAF hospitalization. Small stations isolated from civilian communities, active flying with the attendant severe accidents, and pressure for care of dependents, have forced them to provide more hospitalization than would ordinarily be justified. Obviously, it is more expensive to operate 7,500 beds in a number of small hospitals than in twelve (12) to twenty (20) large installations, and this has become a major planning item.

Colonel Cook stated that plans had been made for the air evacuation of patients from domestic military hospitals but several decisions still had to be made. He told the army surgeons and center commanders that in an emergency if they would call the surgeon at any AAF station, he would arrange for evacuation of the patient.

DISCUSSION:

General Baylis brought up the question of whether or not vouchers for civilian medical care of Air Forces personnel should be audited in the army headquarters. Colonel Cook stated that it was his opinion that the army area should continue to handle these papers.

Colonel Williams stated that at present his headquarters was handling certification of payment of civilian medical attendance for Army Air Forces personnel, LOD, request for waivers and physical examinations (non-flying) and requested an opinion of this. Colonel Cook stated that under Circular 138, the Air Forces should take over the approval of waivers and investigation of LOD. He further stated that if the AAF did not have the trained personnel to do it, the function should be transferred and then the personnel procured.

General Walson stated that recently a number of his hospitals had been reduced to dispensary level and questioned the advisability of continuing the provision that patients could be held in the dispensaries only forty-eight (48) hours. Colonel McGibony explained that this was being amended in a revision of WD Circular 12.

Question 1: What will be the policy on the type of medical and surgical care to be provided in station hospitals after regional hospitals are no longer in existence? What changes are contemplated in WD Circular 12, 1946?

Answer : A return to the pre-war station and general hospital system is contemplated. Circular 12 is being revised at present.

Question 2: What changes are contemplated in ASF Circular 89, 1945, when the regional hospitals are no longer in existence, especially in view of the fact that it is becoming more and more difficult to staff station hospitals with enough specialists to perform functions listed for station hospitals in WD Circular 12?. 1??

Answer : No changes are contemplated in ASF Circular 89, but it is hoped that certain designated station hospitals will be adequately staffed to perform the functions listed for station hospitals in Circular 12.

Question 3: How long will the Veterans Administration be authorized beds in station hospitals, especially after the regional hospitals (such as occurred at Fort Knox) revert to station hospitals?

Answer : The Veterans Administration will be authorized beds in station hospitals for an indefinite time.

Question 4: At the Louisville Medical Depot there is an industrial dispensary which is a Class I function at a Class II installation. What is the policy of The Surgeon General in regard to coordination between the army surgeon and The Surgeon General of professional activities and of medical supply activities at this depot?

Answer : The Army is responsible for medical care but has nothing to do with the supply activities at this Class II medical supply depot.

Question 5: a. A case occurred in this Army Area whereby civilian medical care in a civilian hospital was requested for a patient now in a general hospital. This request originated with the father of the patient and was approved by the Office of The Surgeon General. The general hospital then requested the Commanding General, Second Army, to approve request for civilian medical care.

b. AR 40-505 which authorized service command surgeons to approve applications for civilian medical care, seems to have been superseded in part by WD Circular 138, which states that the commanding general of each army is not responsible for medical and dental care at general hospitals. What is the policy of The Surgeon General and the War Department in cases of this kind?

Answer: The answer to this question is contained in memorandum from Legal Division to Fiscal Division, SGO, dated 12 July 1946.

"MEMORANDUM TO: Major Fogelberg
Director, Fiscal Division
Room 2C 295

SUBJECT: Authority to Engage Civilian Medical Attendance for a Patient in a General Hospital.

1. Correspondence in the case of John R. Boswell, Pfc, 35844480, patient at Valley Forge General Hospital has been reviewed.

2. It is the opinion of the Legal Division that the 4th Indorsement, Headquarters Second Army is correct in that the Commanding General of the Army Area has no jurisdiction in this matter.

3. There appears to be a conflict at this time between par. 6w, Appendix II, WD Circular 148, 1946 and par. 3d(1), AR 40-505, 5 December 1945. The paragraph in the Army Regulations indicates that prior approval of the Commanding General of the service command is necessary for civilian medical attendance. It is pointed out that the Army Regulations have not as yet caught up to the War Department reorganization directed by WD Cir. 138. In such case the regulations are controlled by the circular. Therefore, it is the opinion of the Legal Division that approval of the Commanding General of the Army Area (vice service command) is not necessary before securing civilian medical attendance for a patient in a general hospital (par. 6w, WD Cir. 148).

4. This matter was checked with General Denit's office and the Operations Service concurs in the opinion of the Legal Division. The Commanding General of the

General Hospital and The Surgeon General are responsible for care of patients in such hospital. Such matters do not concern the Commanding General of the Army."

E. R. TAYLOR
Captain, JAGD
Director, Legal Division"

Incl.
Correspondence

Question 6: At the New Orleans Port of Embarkation the Fourth Army is responsible for medical, dental and veterinary service except aboard army transports. The Port Surgeon is therefore carrying out a dual role and carrying dual responsibilities to the Commanding General, Fourth Army, and the Commanding General of the Port -- a Class II installation. We believe that the Port Surgeon is perfectly capable of discharging this dual responsibility with economy and efficiency. However, to simplify this personnel problem we would recommend that The Surgeon General assign officers to the Port Commander, including medical, dental and veterinary, for transport duty by name and MOS, and that we make the assignments by name and MOS to the station medical activities, and that station medical personnel not be assigned to transport duty without concurrence of this office.

Answer : Major Campbell states that by arrangement between General Denit and General Leavey, officers are being assigned by The Surgeon General to the Port Commander for transport duty.

Question 7: Request clarification of Information and Education and Special Service activities for patients and duty personnel at Class II medical installations. It is intended that Special Services apply to both patients and duty personnel or that pertaining to patients be a Red Cross responsibility?

Answer : The Information and Education Program has a dual responsibility in a hospital. Neither of the responsibilities are paramount but both responsibilities must be considered and given equal consideration. These functions are Information and Education for patients and Information and Education for detachment personnel. The I. & E. program as outlined in WD Circular 291, 1945; WD Circular 100, 1946; and WD Circular 195, 1946, apply to both duty and patient personnel.

The Special Services program in a hospital also had a dual responsibility with equal consideration for both phases of the program, for patients and for duty personnel. The Red Cross has a primary responsibility in hospitals for recreation and social services for patients. A complete and successful hospital diversion program can be accomplished only by complete coordination of the Red Cross and the Special Services activities. WD Circular 86, 1945, Section I, and AR 850-75 outline clearly the responsibility of the American Red Cross units assigned to hospitals.

There are, at present, some differences with regard to the proper assignment of Special Services personnel so far as Army Service Unit or Technical Service Unit is concerned. A clarifying directive on this will be out in the field on completion of conferences now being held on this question between The Surgeon General's Office and Special Services Division, War Department. Information and Education activities are assigned to the Technical Services Unit by WD Circular 170, 1946, and the responsibility for the Information and Education Program in all Class II installations has been placed with the Chief of the Technical Service; in this case, The Surgeon General. At station and regional hospitals, Information and Education and Special Services programs are still the responsibility of the army commanders.

Question 8: What is the responsibility of the Army Surgeon in the closure of general hospitals?

Answer : The army surgeon in the closure of general hospitals has no responsibility except as a staff officer for the commanding general of the army area who has responsibility for closure after last patient has gone.

Question 9: How long does a general hospital remain a Class II installation? Does it remain Class II only as long as patients are present, or does it remain Class II until completely closed out?

Answer : Until completely closed out.

Question 10: Request clarification of Par. 5 and 5a, Section I, War Department Circular 192, c.s. Par 5, states that custodial services will be performed by civilian employees of the Post Engineer who are primarily engaged for such work

whereas Par. 5a continues to provide that all other available personnel at each of the facilities must also be utilized so far as practicable.

Answer : Paragraph 5a, Section I, MD Circular 192, is intended to regulate the maintenance costs and effect uniform standards by having the Chief of Engineers responsible for publication of technical standards and technical inspections relative to custodial services. However, personnel to implement this program was not available under the Engineers budget and hence the second phrase of paragraph 5a, "all other available personnel at each of these facilities must also be utilized," was necessary.

Question 11: Can provision be made to more readily increase the value of the commuted ration for enlisted patients in military hospitals by returning to the former system of fixing the value thereof as a percentage increase to the value of the garrison ration?

Answer : This is being handled now by a flat rate of 75¢ for enlisted patients and 90¢ for tuberculous patients. Mr. McGillen, Chief, Hospital Fund Branch, SGO, states that it is not contemplated returning to the system of the ration plus a certain percent. He says that on June 25th an indorsement was sent out from the Hospital Fund Office relative to this.

Question 12: Is the continued use of Air Corps regional hospitals by Class I and II installations contemplated? If so, what is the procedure for making necessary arrangements for their use?

Answer : The answer is that regional hospitals are going out.

Question 13: Is it permissible to utilize general hospitals for station hospital service for nearby (five to ten miles) small posts, camps and stations?

Answer : It is permissible to utilize general hospitals for station hospital service for nearby small posts, camps and stations.

3. Administration of fixed hospitals in zone of interior. -

Mr. Ross E. Garrett discussed the thought back of the publication of TM 8-262, Administration of Fixed Hospitals. He stated

that it was General Bliss' desire that procedures in the administration of hospitals be defined and set forth in simplified and detailed language and certain standardization be accomplished. This objective has been accomplished in TM 8-262. Standard forms and records used in hospital administration are so simplified and described that it requires little or no training of personnel to handle them. This manual is also valuable in orienting reserve officers upon re-entry on active duty. In time it is expected that a staffing basis can be worked out from the procedures and functions described in the manual and, based on the type patient load in particular hospitals, show how many of what type of personnel will be required for a particular job. Used in this way it could be of help in justifying certain numbers of personnel to the War Department Manpower Board. Mr. Garrett stated that although the manual deals entirely with general hospitals, the army surgeons might be interested in studying it for possible adoption in station hospitals. He asked that any comments or ideas the army surgeons or center commanders might have regarding the manual as it exists be forwarded to the Office of The Surgeon General.

One change that is contemplated for the manual is the function described under organization of the control officer. That function will be carried out by the executive officer and the staff to carry out the administrative details will be assigned to his office.

4. Station complement functions at Class II medical installations. -

Major Russell Murray, MAC, Chief, Personnel Authorization Unit, SGO, stated that the matter of station complements is quite a problem because of the certain functions performed by the engineers and certain other duties performed by the Medical Department for which the army commander is responsible. To get as many people to take care of this situation as the army commander needs and until such time as we can change things the surgeons should let us know when the general hospitals in the areas do not have sufficient personnel allocated by the army.

DISCUSSION:

GENERAL WILLIS: Brooke Army Medical Center had to turn over to the army area 256 bodies.

GENERAL BLISS: Do the army surgeons all know how the allocations go to the general hospital? The War Manpower Board allotted seventy (70) bodies per bed capacity of hospital. Of those seventy (70) bodies, there are assigned to The Surgeon General for duty in general hospitals, fifty (50). These are given to this office for assignment for

things for which the chiefs of technical services are responsible, leaving twenty (20)not assigned on bulk allotments. Now, what we want to know is do these twenty (20) bodies ever reach Army hospitals? Do the hospitals have anything to do with allotting of these men to their installations within the army areas?

GENERAL WILLIS: It took ten (10) days, or two (2) weeks to find out what had actually taken place with the 256 men turned over to the Army.

GENERAL BLISS: The War Department Manpower Board allots 52,000 men for general hospitals. The Surgeon General is allotted 42,000. The other 10,000 go in bulk to army areas. Are these men going into the hospitals?

GENERAL BAYLIS: I knew nothing about this. It is my understanding that the army area was to furnish such personnel.

COLONEL ROGERS: It was my impression that engineer troops go to the engineers, quartermaster troops to the quartermaster, etc., for distribution. We haven't had any difficulty so far and there has been no trouble in my area.

MAJOR MURRAY: For 30 June there were 69.4 bodies per 100 authorized beds allocated to be the allotment of personnel to operate named general hospitals. A figure of 19.2 bodies per 100 beds was arrived at, which personnel would go to the army headquarters to assist the army commander in performing the functions for which the army commander is responsible. The balance was made to The Surgeon General to accomplish his mission in general hospitals, or a total of 50.2 personnel per 100 authorized beds to perform the functions assigned to The Surgeon General. The answer to this problem was to contact the army commander and tell him the army area responsibilities to be performed at these installations were not being done, by reason of the fact that necessary duty personnel were not being supplied by the army commander to the post commander.

GENERAL BAYLIS: I discussed this in my army area with the control personnel in headquarters. They gave me the same figure as to personnel which the War Department is giving me. The figures for this personnel are not in numbers, but in percentages.

MAJOR MURRAY: When these numbers of personnel get to the army commanders, they have a general idea as to what is allotted to each function. How it is distributed is up to the army commander and naturally the army commander's responsibility will come first with him.

GENERAL BEACH: There is no trouble with this type of personnel at the Army Medical Center.

GENERAL BAYLIS: I am glad to hear that two (2) individuals here get the personnel they need.

GENERAL WALSON: I would like to have clarification of the terms TSU and ASU. (Technical Service Unit and Army Service Unit.) I would recommend that the two (2) units be abolished and that one (1) unit only be substituted.

GENERAL BLISS: I would like to recommend that the 10,000 miscellaneous personnel be transferred to the jurisdiction of The Surgeon General for allotment and distribution to general hospitals.

COLONEL ROGERS: I do not know of any trouble with such personnel in my headquarters. Consideration is being given there to the policy whereby the army surgeons will be advised as to the allotments and transfers to TSU's of general hospitals. We are to be kept continually informed there on this. With the rapidly increasing scarcity of qualified specialists throughout the areas the army surgeon should know his situation in the areas. Recommend that army surgeons be kept continually advised with the allotment of transfers of TSU's at general hospitals.

GENERAL WILLIS: This would be too much responsibility for the responsible party.

GENERAL DENIT: What is the custom to be, or what is the custom now, by which we can keep army surgeons informed as to just what personnel is in their hospitals?

COLONEL WILLIAMS: Is the personnel on duty at a numbered general hospital stationed at a named general hospital a part of the 50.2 personnel allotted to that installation?

MAJOR MURRAY: This is an entirely different allotment as these are general reserve units. There is no way from the level of the Office of The Surgeon General that we can tell what the allotment to a TSU is. This office can, however, submit to the army surgeon a copy of such information as sent to the army commander, but I do not think this would help the situation.

GENERAL BAYLIS: In my opinion when things are more stabilized, it will be possible to get more information. Is it my understanding that the commanding general of the army is responsible for the number of personnel allotted to general hospitals in their areas for maintenance work, etc? None of the army surgeons had ever heard of this allotment before and will try to find out about it at their home headquarters.

GENERAL WALSON: The commanding officers of my hospitals call up and say they are having difficulty. They were allotted personnel to do certain duties and these were frozen as an ASU. Since then, the personnel becomes eligible for separation from the service and replacements for this personnel are at a backlog.

GENERAL BAYLIS: I have also received such requests but no information along this line.

Question 1: The hospitals in the Fifth Service Command were visited recently and a serious problem presented itself in the hospitals in that area. The nurses have been on a straight eight-hour schedule of duty, as follows: 7 AM to 3 PM; 3 PM to 11 PM; 11 PM to 7 AM. This schedule requires an increase of approximately twenty-five per cent (25%) in the number of nurses required to cover the nursing service. The hospitals in the Fifth Service Command previously had sufficient nurses to use the eight-hour day. The present authorization will reduce their number to a point where it will not be possible to maintain that schedule of hours. Most of the hospitals in the Third Service Command had not been able to adopt the eight-hour day because the increase in authorization requiredfor that schedule had never been approved by ASF. Sometime in the past, all service commands were requested by telephone from The Surgeon General's Office to use the eight-hour day wherever possible, but because there was no directive or written authority to cover this change, the Personnel Authorization Division of the Third Service Command did not approve an increase in authorization for the change of schedule. In order to obtain uniformity and prevent a decrease in morale incident to a change in hours of Fifth Service Command nurses, will a definite policy be forthcoming from the Office of The Surgeon General?

Answer: The determination for authorization for the Army Nurse Corps (as well as all other Medical Department Personnel) is established as set forth in WD Circular 209, 1944 Manning Table. If there is to be any deviation in strength authorization it would come from the War Manpower Board. The WDMB would inform The Surgeon General to absorb the increased ANC requirements from within the overall personnel authorization. It is not possible to do this without injuring other services performed by other type personnel. It therefore seems imperative to change the Manning Guide so as to reflect an increase in total personnel as well in ANC.

This office is constantly in contact with the WDMB in reference to increase in personnel ceilings and since the WDMB sets definite ceilings there seems to be no relief for any increase unless the basis for WDMB determination (Manning Guide) is changed.

The situation appears to be similar in General Hospitals, personnel authorizations for which are furnished by The Surgeon General as well as in regional and station hospitals, authorizations for which are made by army area commanders.

5. Maintenance, repair and utilities at Class II medical installations. -

Mr. Frank M. Chedester, Office of the Chief of Engineers, prefaced his remarks by stating that he had been asked by Colonel Ehrgott, Chief of Repairs and Utilities Division, Office of the Chief of Engineers, to present his regrets at his inability to attend the conference.

Mr. Chedester gave a brief summary of the work done by Repairs and Utilities Division of Office, Chief of Engineers, so that the army surgeons might be able to understand a little more clearly how maintenance functions in hospital operation. The post engineer tries to keep the hospital buildings, utilities, and installed equipment in condition to serve their intended purpose. If this is not done, then the responsibility is his to perform maintenance and repair. Most changes in these functions took place while the army surgeons were not in the zone of interior. In 1941, repairs and utilities were assigned to Office of the Chief of Engineers, by Act of Congress. The repairs and utilities functions may be set up in four (4) categories. The Office, Chief of Engineers, is organized along these lines, and parallels very closely the organization of the repairs and utilities division of the engineer section in army headquarters. These groups are: (a) The Management Branch, which takes care of funds, statistics, budget, and general needs (b) The Utilities Branch, which sees that there is provided needed services in heat, light, water, sewage, ventilation, air conditioning, any gas that might be available at particular stations, and utilities rate adjustment where electricity is purchased principally from outside sources (c) The Fire Prevention Branch, which includes both inspection and instruction in how to prevent fires, and equipping and instructing the fire departments at stations to fight fires when they break out. We are a little proud of this record through the war. (d) The Maintenance and Repair Branch, which includes supervision of practically all work on buildings, walks, roads, grounds, insect and rodent control, custodial services, and refuse collection and disposal.

To carry out this responsibility, the engineer organization parallels very closely that of the Medical Department. The army engineer is a staff officer serving in an advisory capacity only. He acts in a staff echelon with the army surgeon and has similar difficulties. It would be well in the future if the army surgeons, when faced with a maintenance problem at a hospital, would see the army engineer.

In the air forces, there is also a tremendous problem to them and to us. Office, Chief of Engineers responsibility with the Army Air Forces is now limited primarily to policy, and inspections to see the War Department policy is carried out. The actual responsibility for operation of repairs and utilities now belongs to Army Air Forces.

The division and district engineers handle new construction, river and harbor work, and procurement almost exclusively. They have no part in the operation of a hospital after the initial construction has been completed, until such time as it might be declared surplus. In that case, the Chief of Engineers takes over the property.

Although the entire physical plant from the main gate to the back fence has to do with an efficiently operating hospital plant, main interest in a hospital centers in the buildings. Our basic job, of course, despite lack of an adequate maintenance force in some cases, is to try to do the best possible job of keeping the initial construction at a state of usefulness. The immediate problem is to find the best possible way we can do it with the money and materials available.

One of the newest activities we now have is the custodial service responsibility. War Department Circular 192, 1946, assigns this responsibility to repair and utilities. Like at station hospitals, the repairs and utilities at general hospitals are an army responsibility, and supervision falls to the army engineer in his staff responsibility to the army commander. There is a statement in Circular 192 requiring the best efforts of the post and hospital commanders to arrange the most efficient use of available personnel for the carrying out of custodial responsibility. While the post engineer is responsible for funds and personnel, available military or civilian personnel will continue to be used for such work. We cannot tell how this should be worked out. It should be worked out individually at hospitals, but if there is any reason why it cannot be worked out at any one installation, it should come through channels for settlement in army headquarters. Only in rare instances should it reach the SGO. The case for central control and training on this subject is probably best illustrated by an actual inspection report from one (1) of the general hospitals. This particular hospital had five (5) definitely separated areas. There was no man or

person of any sort responsible for the custodial function in the hospital. In one (1) area an enlisted man was janitor. Through a change of officers on the post and through the best help of experts on custodial services from army headquarters and Office, Chief of Engineers, the services are now being handled by the post engineer, who has the definite responsibility for the work and is getting specialists to accomplish it. There is every reason to believe that results will be very much better within a very short time. In the spring and summer of 1945 we were able to accomplish the most necessary items of work to bring the then sixty-five (65) general and convalescent hospitals up to a totally acceptable condition for extended use. It was not the ultimate, but those hospitals were certainly very much better than before.

Through the activities of General Kirk and General Wheeler, Chief of Engineers, a bill has recently been passed by Congress authorizing fund to at least get started on deferred maintenance for additional hospitals. This will apply to station and regional hospitals, whether under the armies or the Army Air Forces, at stations selected for postwar utilization. If the station is known to have a very limited life, then these funds will not be available. We know that with the money available, which is not enough, and with the critical material supply, it will take two (2) years or more to complete the work which will be the minimum acceptable to the Medical Department, the Corps of Engineers and the War Department Staff. Unfortunately, materials are considered in most respects more critical than they were during the war period. Paint is just about the scarcest item. Plywood for floor covering underlay is practically unobtainable. The Office, Chief of Engineers is doing what it can to get material for this work.

At this point Mr. Chedester read a paper giving the most important general items for deferred maintenance of hospitals and said that if any individual hospital has a particular need not mentioned in this criteria, there is no bar whatsoever against approval of a project to correct this situation, provided it is submitted with sufficient justification and is within the limit of available funds. These necessary items for repairs and improvements include, not in order of importance, such things as, laying of floor-covering, exterior painting, re-roofing where necessary, interior lining, insulation, wainscoting, interior painting, etc. It provides for improvement of diet kitchens, including some new equipment and rearranging of existing equipment. He also includes repairs and improvements on roads, walks, drainage systems, grounds, including lawns, shade trees, shrubbery and control of dust and erosion; electrical work, heating, special boiler water treatment, installation of automatic firing equipment, and insulation of exposed steam piping. These cover the main items and are only suggestions. They will be sent to armies and stations, together with technical data, to insure uniformity and a uniformly high standard in the work that

is done. It was thought that the money for this repair work would be available in FY 1946. Now it is, in part, and we will try this year to get all items up to date. Rather than accomplish a little of this and a little of that, it has been decided to finish one particular item throughout and leave a less pressing item for money which we have every reason to believe will be forthcoming next year and possibly in the years to come.

Along with the hospital work, there is a special sum of money available, in not nearly as high a proportion as for the station and regional hospitals, for improvement of general camp areas. The only part of the station hospitals to which that money will be applicable will be exterior painting, re-roofing, and such work as that on the station complement facilities not considered in patient areas.

Mr. Chedester stated that he could probably talk about this subject all night, but would stop for questions.

DISCUSSION:

GENERAL WALSON: When will the engineers be able to start fixing up station hospitals?

MR. CHEDESTER: A circular will probably be out within the next two (2) weeks relative to this matter.

GENERAL WALSON: Has this authority for repairs been sent to army headquarters as yet?

MR. CHEDESTER: The Act was passed by Congress two (2) weeks ago and the information has not yet been forwarded. The Office, Chief of Engineers is working on this.

GENERAL BAYLIS: Will this money be specifically allocated for hospitals?

MR. CHEDESTER: For the items marked, for general and station hospitals. The hospital allocation is frozen out of the total, so it should be mentioned that the request for funds might be submitted higher than the total funds allocated.

GENERAL BAYLIS: Will this go down through the army commanders to allot what amount of money is needed?

MR. CHEDESTER: There will be a breakdown on a square foot basis and the number of beds to determine the amount provided the army area. It will be up to the army to subdivide the money and state what are the most pressing matters requiring priority.

GENERAL WALSON: Does this money go to the army commander with instructions that the money will be used for army hospitals?

MR. CHEDESTER: They will be so instructed.

GENERAL WALSON: Is there any money specifically allotted for rodent control?

MR. CHEDESTER: This will be based on experience of previous years and what so far has been done in that aspect.

GENERAL WALSON: What will be figured as overhead on these projects at War Department level, and then go down to army level as overhead costs?

MR. CHEDESTER: There will be made available to the army commander a certain lump sum. How he breaks it down is not known. The station will prepare projects on AGO Form 5-25, (Regular Project Estimate Form), and submit them to the army engineer to be acted on like any ordinary matter, except that they will be charged against this special deferred maintenance money.

COLONEL SOUDER: (Chief, Hospital Construction Branch, SGO) Doesn't there have to be a special army overhead for construction?

MR. CHEDESTER: This is usually included.

GENERAL BAYLIS: It is up to the post and station commanders to put up requests for the projects they want done. If it requires additional personnel to do the work, is this request put in along with the estimate? If it can be done with personnel already on the post, the residue can be done by the military, can it not?

MR. CHEDESTER: Because most work is done by regular employees rather than by contract, there is very little overhead. The overhead of the post engineer and the army engineer offices have already been taken up in these organizations, and very little overhead is expected unless the repair projects are contracted for.

GENERAL WALSON: Reference War Department Circular 192, custodial care is quite a problem, however, this won't be so difficult for the commanding officer of a general hospital to control all of the personnel there are under his control except the ASU. Sometimes a general hospital is based on a large post for repairs and utilities. This puts the general hospital down to the station hospital status, where the personnel is allotted to the post commander and the engineer officer is given a lot to do by the post commander. The post engineer is theoretically responsible for both.

GENERAL WILLIS: There is always an interminable delay to get minor repairs done.

GENERAL BAYLIS: Agreed! At some stations they won't even give the parts to use for repairs with our own personnel.

MR. CHEDESTER: When such situations occur, the army surgeons should go right to the army engineer.

GENERAL WILLIS: The post engineer at Brooke is the post engineer at Fort Sam Houston and just hasn't got the personnel to do the work. The activities at Brooke have increased 100% and the work has increased 50%.

GENERAL BAYLIS: At some stations they are trying to freeze personnel available to do this work provided they can get the equipment. This consolidation and reduction throughout the army may save personnel, but it certainly does not get results.

6. Use of hospital funds.-

There was no discussion of hospital funds at the conference. The following questions submitted by army surgeons are stated together with the answers prepared by the Office of The Surgeon General:

Question 1: Is it contemplated that army surgeons continue to have the responsibility for auditing hospital fund statements and investigating undue losses in messes pertaining to Class III hospitals?

Answer : No. Section IV of War Department Circular 182, 1946, prescribes that for Class III hospitals the administrative responsibilities with respect to reviewing hospital fund reports, including investigations of causes of deficits in fund net working capital, will be performed by the appropriate air force commander. If hospital fund reports or letters pertaining to hospital fund activities are received by army surgeons from Class III installations, they should be referred to the air force command having jurisdiction over the installation or returned to the station for routing through air force channels.

Question 2: A double-entry system of book-keeping is required for reporting transactions of the hospital fund. In the smaller hospitals, due to personnel ceilings and rapid turnovers in personnel, qualified individuals of any permanence are hard to obtain, resulting in errors and omissions in the accounts which are not discovered until the fund is audited by an experienced auditor.

Why not authorize, at the expense of the fund, the employment of a permanent civilian employee whose duty will be to keep records on all transactions of the hospital fund, including all records required, and adequate control of the storage and issue of food supplies? This office is receiving requests from Class III installations for authority to effect disposition of hospital fund durable property. Section IV, War Department Circular 182, 1946, places responsibility for the administration of hospital funds at Class III installations on the nearest Army Air Forces commander. This apparently rescinds SGO Letter, dated 18 March 1946, subject, "Disposition of Hospital Fund Property." Clarification is requested.

Answer : Civilian employees.- The employment of Civil Service employees of the Medical Department for the performance of duties in connection with hospital fund activities at hospitals is authorized. In accordance with Par 18a (1), AR 40-590, hospital funds and the acitivities financed by them are government instrumentalities performing functions in the care and treatment of patients. Provision is made in the annual appropriation acts for the military establishment (Medical and Hospital Department) for the employment of such personnel and the payment of their salaries. Since hospital fund expenditures may not be made for any purpose for which appropriated funds are available, the employment of civilians at the expense of the Fund is unauthorized. It is recommended that hospital commanders give serious consideration to securing qualified individuals for this purpose.

Disposition of hospital fund property.- A War Department circular now in process of being printed will provide for the decentralized disposition of hospital fund property as follows: (1) Class I installations - appropriate army commander (2) Class II installations: (a) medical centers and general hospitals - The Surgeon General (b) Class II installations other than medical centers and general hospitals - appropriate army commander, (3) Class III installations - appropriate Army Air Forces commander. This directive will rescind the authority contained in letter from this office, dated 18 March 1946, subject: "Disposition of Hospital Fund Durable Property."

Question 3: What procedure should be followed in settling unpaid accounts outstanding against hospital funds of general hospitals which have been closed? (To cite a specific case, McGuire General Hospital).

Answer : In accordance with Par 18c(5), AR 40-590 all hospital fund obligations should be paid prior to the closing of the hospital fund. Where, because of unusual circumstances, payment of a specific obligation or obligations cannot be accomplished prior to the closing of the hospital fund, such obligation may be assigned to the Central Hospital Fund, this office. Special attention is directed to Section I, War Department Circular 205, 1946. Full compliance with the provisions of this directive will, with the exception of unusual instances, eliminate outstanding accounts against hospital funds of closed hospitals. In this connection the auditing of hospital funds at Class II installations is a Finance Department activity and the responsibility of the appropriate army commander (War Department Circular 138, 1946, Par 32 (page 12) and Appendix II, Par 6 (page 30)). The specific case cited (McGuire General Hospital) is assumed to be an obligation for the expenditure of watchmaking equipment in account with C. and E. Marshall Company, on which payment could not be accomplished at the time the hospital fund was closed.

Question 4: When hospitals are being closed, disposition of durable property of the hospital fund has been delegated to the commanding general of the army by The Surgeon General. Disposition of subsistence items is still controlled by The Surgeon General in accordance with provisions of paragraph 18c(5)(a) AR 40-590. This has resulted in delay in settlement of the hospital fund and puts an added burden upon personnel engaged in the closure of the hospital. Is any change contemplated in AR 40-590 in this regard?

Answer : Disposition of hospital fund durable property.- See paragraph 2 of answer to Question 2.

Disposition of Subsistence Supplies.- The following procedure is contemplated by Par 18c(5)(a), AR 40-590:

(1) All subsistence items to the extent practicable will be returned to the quartermaster sales officer for credit.

(2) Items not returnable to the quartermaster sales officer will be: (a) sold at cost value to other organizations on the post; (b) transferred to hospital funds of other hospitals with reimbursement at cost value; (c) offered for public sale at cost value provided disposition under (a) and (b) above, is not practicable of accomplishment.

The words "or disposed of" as used in the above-cited Army Regulations are intended to cover subsistence items comprising open containers, broken packages, etc., which may be disposed of to other army messes without reimbursement. It is contemplated to modify this portion of the regulations to conform with the above in the forthcoming revision of AR 40-590.

H. PERSONNEL PROBLEMS..... Colonel Francis P. Kintz
Professional Consultants
Officers and Civilians

1. The use of Medical Department specialists and consultants.-

Colonel Arden Freer, M.C., Chief, Medical Consultants Division, SGO, made the following statement: The professional consultants are considered in three (3) groups and as stated in War Department Circular 101, c.s., during World War II The Surgeon General developed a system of utilization of professional consultants from which great benefit was derived (reference is made to War Department Circular 12, 1946). In order to insure the maintenance of the highest professional standards and to provide close liaison with leaders in the medical profession at large, this system will be continued and extended in the future. Professional consultants who are recognized experts in the medical and allied specialties, including internal medicine, surgery, neuropsychiatry, preventive medicine, dentistry, veterinary medicine, and other special medical fields, will be designated by The Surgeon General.

There is a new regulation on the three (3) groups of consultants which will eliminate the procurement of individual consultants for individual applicants as has been prescribed for years in AR 30-45. Where there are individual cases for individual patients, this is in addition to the old policy. Additional details are given in the circular just now abstracted concerning the responsibilities of a consultant whether on a civilian status of active duty reserve status. These consultants are divided into three (3) groups as follows:

Office of The Surgeon General

Army Area Group, or, as stated in Circular 101, Lower Echelon Headquarters Group

Special teaching consultants, or, as also mentioned in WD Circular 101, army hospitals and other medical installations in the United States.

All are appointed by the Secretary of War upon recommendations by The Surgeon General. The word, "expert" has been added to other adjectives in connection with these consultants for reasons to be explained later on by Mr. LaCross of Civilian Personnel Service, but I might say it is used for financial reasons.

The headquarters group are assigned to this office on special work, or may be assigned to field trips. Consultants will visit general hospitals in army areas including both area hospitals, which come under the jurisdiction of the army surgeon and Army Air Forces installations as has been mentioned previously today and will be discussed in further detail. In connection with this group you have been given a copy of the letter to hospital commanders and the letter to the army surgeons addressed to the commanding general of the army concerned. (See letters, Office of The Surgeon General, subjects: "Expert Consultant Service and Travel", and, "Civilian Expert Consultants", attached hereto as inclosures No. 3 and 4.

When an area consultant trip is planned, it is contemplated contacting the Office of the Air Surgeon and then sending a note to you asking that you have the consultant include the Army Air Forces hospital on his itinerary. If, in the absence of such a note, you know that the commanding officer of the air hospital will need the consultant his visit to this installation will be approved and reports must be made by the consultants through technical channels.

The previous two (2) groups are the same consultants and in most cases the same people used throughout the war. The hospital teaching consultants as stated in a letter which has been prepared and gone out to hospital commanders are a program for the graduate education of personnel on duty at these hospitals. The latter group will be notified to meet the requirements for the station hospitals. It is contemplated that consultants in medicine and surgery will be provided for all general hospitals. Seven (7) general and regional hospitals and possibly an eighth to be added and three (3) Army Air Forces hospitals have been approved by the American Medical Association. Consultants in other specialties will be obtained for other hospitals in which certain specialties have been approved such as pediatrics, etc.

At this point, questions submitted in advance by the army surgeons were read and the answers as supplied by the appropriate consultant divisions were presented by Colonel Blitch, MC, Assistant, Medical Consultants Division, Office of The Surgeon General.

DISCUSSION:

Question 1: When will a definite policy be established for the appointment and utilization of civilian consultants? How are they to be paid? Who is to issue orders for their visits of inspection? Are they to be assigned to The Surgeon General or are they to be assigned to the commanding general of the army? What is their status relative to The Surgeon General and relative

to the commanding general of the army? What will be the policy in regard to utilizing the civilian consultants to augment the graduate professional training program of medical officers?

Answer : A definite policy has now been established for the appointment of civilian consultants. The policy of the utilization of these consultants is also definite, but flexible. Consultants are appointed by the Secretary of War upon the recommendation of The Surgeon General. The names submitted by The Surgeon General are obtained in various ways. Some are those who have previously been associated with the office; others are recommended by the hospital commander, or other individuals of known repute. Before names are submitted, the individual record is carefully studied. Insofar as possible only those men who are diplomats of the specialty boards are submitted. This is especially true for those consultants who are to be used chiefly in the hospitals as teaching consultants. The utilization of these consultants, as stated above, is flexible as is indicated in paragraph 1 of the "form letter" to the commanding general of each army notifying him of the availability of the consultant. These consultants whose appointments are chiefly for use in army areas are to be used as the army surgeon desires. They may be used for the purpose of observing the standards of professional work, checking on the personnel and problems connected therewith, and other similar phases of work. However, the army surgeon may wish to have a consultant spend more time at one hospital, observing more in detail and conducting clinics, ward rounds, or other types of instructions.

Consultants will be paid as directed in paragraph 6 of "form letter" to commanding generals of army areas.

Orders will be issued by the commanding general of army concerned, as outlined in paragraph 2, same letter.

Civilian consultants are appointed as expert consultants to The Surgeon General, as also noted in letter referred to above.

Expert consultants are, while actually employed personnel of The Surgeon General, detailed to the commanding generals of the armies, as authorized by the professional consultant divisions of this office.

The policy in regard to utilizing the civilian consultants to augment the graduate professional training program of Medical Corps officers is that they can be used for this purpose, along with other duties. It is assumed that this question refers to the army consultants.

Question 2: What various specialties are to be represented among civilian professional consultants? Will the policies permit their use on a part-time basis once or twice a week or for consultation for individual cases?

Answer : Consultants being appointed primarily as area consultants will be chiefly general medical, general surgical, and neuropsychiatric. However, where situations or conditions exist or develop requiring some special type of consultant, these may be made available by The Surgeon General. Utilization of the services of the area consultants is authorized in any of our medical installations, incident to their scheduled visits.

There followed a general discussion by the conferees:

GENERAL BAYLIS: I would like to know if we pay consultants twenty-five dollars ($25.00) a day?

MR. LACROSS, Civilian Personnel Service, SGO: Permission was asked to pay fifty dollars ($50.00) a day to expert consultants. Congress has compromised on this and authorized forty dollars ($40.00). This was agreeable to The Surgeon General and in order that the high standards developed throughout the war in army hospitals are kept up we will use this rate. The Military Act of 1947 is still in Congress and not signed. This calls for a maximum rate of forty dollars ($40.00) per day. We have asked, and the Secretary of War has recently approved, all of our consultant doctors who are diplomats of specialty boards or fellows of the American College of Surgeons or highly technical men whose earning power would be from twelve thousand dollars a year up, so that most of the specialists who are army area consultants will be forty dollar ($40.00) per day men.

GENERAL WALSON: What about the veterans giving fifty dollars ($50.00) per day to their consultants?

MR. LACROSS: This is a special purpose of the Veterans Administration.

COLONEL FREER: The veterans give fifty dollars ($50.00) a day to some and twenty-five dollars ($25.00) to others.

GENERAL WALSON: It was agreed that these consultants should be inconvenienced as little as possible. A busy doctor resents having to make a trip. The doctor thinks he should go to a hospital directly for a visit. Is there any way they can be paid money available other than we now have?

GENERAL BLISS: The system of paying consultants is very complicated as far as The Surgeon General and army area are concerned, but not as far as the hospital is concerned.

COLONEL FREER: Everything possible should be done to organize a consultant's trip judiciously to save time as well as to minimize the travel for which we are using his skilled qualifications. The consultant should take in installations on the way and then be prepared to discuss findings on reporting to headquarters before starting on the trip, otherwise consultants may be lacking many details of value to the army surgeon.

GENERAL BLISS: Is it possible, or not possible, to revise the letter to the army areas so that it will be the same as that to the army hospital commander?

MR. IACROSS: Pay and travel can be arranged in any way you want it if it did not have to go to Congress who limits the funds for our use and for Government employees. Laws are administered with the minimum amount of difficulty to the army surgeons and consultants and everybody concerned. The army surgeons will remember that in the latter part of the fiscal year1946, we tried to have consultants paid in the army areas like consultants were paid in hospitals. The result was chaos and no payment was made so that the Office of The Secretary of War authorized payment from the office which has control. This control is to be maintained in this office. Many hours have been worked to make up this simple plan for their pay. They could be paid in the army areas if The Surgeon General wants to relinquish control to the army areas. Most of the errors have been worked out, but we are trying to make the least inconvenience to the consultant and speed up his pay because all during the War, and for the past six (6) years, consultants have been paid through this office. When it was put to the areas to pay, they had to deal with individual finance offices throughout the United States, which confused matters considerably. At the present time there is a limitation on travel allotments and strict control of funds. All consultant appointments are automatically concluded on 30 June, end of the fiscal year.

GENERAL WILLIS: This work should be simplified as much as possible, but if the law is the law, then it must be complied with.

COLONEL FREER: Papers must be completed by the consultants who come on duty. A pay voucher must be completed with each trip, fingerprints taken, etc. If this is inconveniencing, the First Army could send a man to the consultant's office to do the work for him.

GENERAL BAYLIS: Do we have to come to The Surgeon General before we can get a consultant to go out some place? This is not very feasible.

MR. LACROSS: After an officer has served on duty, an army surgeon may send a certificate in to the effect that the man has served so many days. Now there are two (2) things best so far for travel money and this must be controlled from some one point. If it is not controlled from the army area then it will be arranged so that all pay is completed from one (1) source.

COLONEL ROGERS: There has been a lot of confusion on this. Couldn't all travel be taken care of in one (1) payment?

MR. LACROSS: With the cut on telephone calls, etc., all consultants have to be notified. Letters now have to take care of this. Every time we think we have something well over the line, Congress changes something and then we also have to change.

GENERAL BAYLIS: If there is some simple way where The Surgeon General tells the army surgeon he has the prerogatives of using so many consultants, say for the month of August, and he is able to use them where and when he wants them at any time, it will simplify matters very much.

MR. LACROSS: This must be controlled by the fact that travel funds are limited.

GENERAL BAYLIS: If the army surgeons knew what they were up against they could actually get greater returns from their consultants.

GENERAL WALSON: It doesn't make a great deal of difference whether The Surgeon General or the army surgeon does or does not make the payment. I do think the whole thing should be handled from one (1) place, either the Office of The Surgeon General or the army areas.

GENERAL BLISS: Do all general hospitals have all consultants or do only certain consultants visit them?

COLONEL FREER: They have unless it is a specialty center then only the consultant concerned.

COLONEL ROGERS: Concerning the teaching consultants, does The Surgeon General want the army surgeons to send the area consultants to the general hospitals? We already have them in this other group as teaching consultants.

COLONEL FREER: Yes! We do want the army surgeons to do this.

GENERAL BLISS: Most of our consultants are the same as before the war. Consultants in hospitals are on the staffs of the hospitals and have specific duties, but they are not on full time.

GENERAL BAYLIS: Is the rate of pay to these teaching consultants the same as to the other consultants?

COLONEL FREER: There will still be a need for this all over the Army and for this reason we kept the old consultants. Some of the teaching consultants available are not in every instance tried out the way this other group has been. As it is, some of these will probably have to be changed so that there is a need for both and this will fill the need in general hospitals.

COLONEL ROGERS: There was a neuropsychiatric consultant who was going to be sent to Chicago which was represented by a Chicago consultant.

COLONEL FREER: Some army areas do not have a wealth of talent that is in other areas and that is why you might not have enough men available in the immediate vicinity so that it might be necessary to cover the area on that. This has been considered from many angles and we have thought of setting it up as part of the hospital group. It is wise that central control be retained over the appointment of these consultants. From the professional standpoint we want good men and to use them as much as possible.

COLONEL COLE, Surgical Consultant: We have had a very, very hard time to get a Class 'A-1' surgeon to agree to take the consultant job in Chicago.

COLONEL ROGERS: The surgical group is very hard to get to take these jobs in Chicago. It seems very strange since it has one of the leading medical centers in the country.

COLONEL CALDWELL, Neuropsychiatric Consultants Division, SGO: It might be necessary to have to send a neuropsychiatric consultant from the East Coast to the West Coast as there are no such consultants in the Fourth and Sixth Army Areas. We do have one (1) in the Fourth Army Area, but we haven't been ble to get him to give any time yet. We finally persuaded Dr. Guttmacher of the Fifth Army to give us ten (10) days and he may have to travel much further than Chicago.

The teaching consultants at Fitzsimons General Hospital are not able to make any trips so in order to get a consultant in that area one (1) will have to be sent from the East. This is another reason for central control, particularly from the viewpoint of The Surgeon General

We have been hounding these men to make these inspection trips.

GENERAL BAYLIS: If you tell us how much money there is and the surgeon feels he will use the allotment of money so it will not be wasted and the area uses the consultant in any way he sees fit, does the office have any more influence over having these consultants give time when he sees fit, this office will concur heartily and will comply with instructions as prescribed by Personnel and Fiscal Divisions.

GENERAL WALSON: I think we should make it a point to emphasize that it is an honor to serve on the staff of The Surgeon General.

COLONEL COLE: This has been put on every basis possible and still we can't get consultants.

Colonel Freer then asked Colonel John M. Caldwell, Chief of Neuropsychiatric Consultants Division, SGO, to present his views on the subject of the use of Medical Department specialists and consultants. Colonel Caldwell made the following statements:

Through a lowering of standards in some cases we have been able to get a neuropsychiatric consultant to make an inspection at the First Army and we would now like to have a neuropsychiatric consultant assigned to Headquarters, First Army. We have asked for twelve (12) neuropsychiatry officers a Mason General Hospital. I would like to add that concerning trips to Class II medical installations, disciplinary barracks and training centers should not be by-passed. Training centers are ground forces installations, some under direct command of The Surgeon General; some Signal Corps; some Quartermaster Corps, etc. We have no control over these installations except as it concerns The Surgeon General. We are putting in an AR that mental hygiene reports will be necessary in the future from these installations. If there is anything the army surgeon can do toward supervising getting information on this from training centers and disciplinary barracks, it will be appreciated.

I might mention the residency training program. The Surgeon General's Circular Letter 44, out today, describes residency training in neuropsychiatry in some detail. This training program in neuropsychiatry will be confined to eight (8) general hospitals, so there are general hospitals where we will have teaching consultants and there are some where we will have travelling consultants go around and see them. There will be no neuropsychiatry training at station or regional hospitals. The residency training program is not confined to Regular Army officers. All officers assigned to these hospitals on this service will be considered as in residency training. At Brooke Army Medical Center there is a neuropsychiatric school. The Army Ground Forces have sent eight (8) men to the present class, the Army Air

Forces have also sent eight (8), and there are twenty-four (24) assigned from The Surgeon General. The question has come up as to whether we will need to continue this school. Is there a need for another course? Resources Analysis Service of this office gives figures projected into July 1947 that we will just break even in neuropsychiatrists for next year. Most men in this line are 'D' men and we would like, if possible, to train this personnel above the 'D' level.

DISCUSSION:

GENERAL WILLIS: We have been able to screen out of the ASTP's at Brooke a certain number of individuals to attend this course.

COLONEL CALDWELL: If there is another course at Brooke, two (2) months from now, would the armies be able to send personnel later. There is also a nurses' school at Brooke and in the army areas there is a shortage of psychologists and psychiatric social workers. It has been shown that a psychologist working by himself is much better working with a team than by himself. We are proposing to establish at Brooke a course for psychologists and social workers. Both officer and enlisted personnel will have to come by allotment out of the army areas.

GENERAL WALSON: If the army sends the personnel to attend these schools, will they get this personnel back?

GENERAL WILLIS: Out of the Brooke School, yes!

GENERAL BAYLIS: I have some personnel for this course and some three (3), four (4), or five (5) will be reported in.

COLONEL CALDWELL: We have just had a spec number given to neuropsychiatric technicians. It is 1409. War Department Circular 209, c.s., covers this. In the army areas, if there are any individuals qualified 1409, we would like to see them so designated. The concept of training neuropsychiatric technicians is that we will need about six per cent (6%) of all new technicians trained in neuropsychiatry. I was informed that medical and surgical technicians cannot be trained at schools, because they are all scheduled for overseas assignments so this will speed up a course for neuropsychiatric technicians and equal allotments will be made to the army areas and these men will be sent back to the army areas.

Under the President's Reorganization Plan 3, St. Elizabeth's Hospital has been closed to all military and naval personnel, so The Surgeon General can no longer send any of this type of personnel to St. Elizabeth's. The present proposed plan at this time is that the

Veterans Administration will take care of all such insane personnel either "line of duty no" or "line of duty yes." Criminal personnel of this type will be taken care of by the FBI.

GENERAL BLISS: Does the FBI run hospitals?

COLONEL FREER: It comes under the Department of Justice, Bureau of Prisons. Heretofore, military and naval mentally unbalanced personnel have been sent to St. Elizabeth's.

GENERAL WALSON: There are about one hundred (100) of the criminal type personnel at Mason General Hospital and they are getting to be quite a problem. What will be done with them?

GENERAL BLISS: These are all to be sent to Leavenworth or to Springfield.

2. Military personnel, including discussion of Central Officers' Assignment Group. -

Colonel Francis P. Kintz, MC, Chief of Personnel, SGO, made the following statements:

Due to the fact that we are behind schedule we have dispensed with several talks concerning various individual personnel items, however, questions relative to MAC officers may be taken up with Major Aabel, Dietitians with Major Burns, and Physical Therapists with Major Vogel. These officers will answer from the floor any particular questions asked about their own individual sections.

The Personnel Section is thoroughly cognizant of your personnel problems in the army areas, so I shall not go into a philosophical discussion of distribution or shortages.

Considerable discussion has developed in the reorganization of the Army of over the Central Officers' Assignment Group. Under the "Simpson Plan" the reorganization of the War Department General Staff Agencies: G-1, G-2, G-3, and G-4 were redesignated as Director of War Department General Staff agencies. Under this directive, G-1 is the Office of Personnel and Administration, under the Director, Major General Willard S. Paul. The Central Officers' Assignment Group is divided into four (4) main groups, as follows: The Central Officers' Assignment Group, Military Personnel Management Group, Manpower Group, and Military Personnel Services Group.

The Central Officers' Assignment Group was developed primarily to control at War Department level, the career training and assignment of officers. The Adjutant General has never had adequate

recommendations to be able to control the careers of officers and their assignments. The Surgeon General has been fortunate in being able to maintain, after much difficulty, records on his officers. Other chiefs of technical services under the Army Service Forces setup lost practically all of their records. Each time there is a meeting of the Central Officers' Assignment Group, it is very evident that we are in a fortunate position compared with some of the others. The Group has now decided to enable all agencies to get their information, duplicate copies of Forms 66-1 (Officers Qualification Cards) will be forwarded to the War Department on all Regular Army, Category I, and volunteer officers. It is necessary for other agencies to bring their records up to date so that they will know what the officer has done and what his assignments have been. The Surgeon General does not need these records because for the past few years by dint of hard work The Surgeon General has been able to maintain these records.

It was originally thought that under the Central Officers' Assignment Group we would lose certain prerogatives in the assignment of Medical Department personnel. So far, I believe I can say we have seen nothing under the setup of the Central Officer's Assignment Group which takes any of The Surgeon General's personnel.

All permanent changes clear through the personnel office of The Surgeon General. In the Central Officers' Assignment Group there is a representative of each of the technical and administrative services and of the major forces. There is, for example, a Medical Branch, represented by myself, a Finance Branch, Ordnance, Quartermaster, Signal Corps, and Ground Forces branches. The latter is broken down into Infantry, Artillery, etc. We are authorized to work directly with other agencies of the Central Officers' Assignment Group and this group only enters into the picture when there is a controversial question which requires staff decision.

An example of this is that if we want an officer from the Ground Forces and the Ground Forces say he is in a key position and cannot be released, then it is referred to the Central Officers' Assignment Group for adjudication.

Under the aegis of the Central Officers' Assignment Group, The Surgeon General will be required to maintain overseas rosters for all personnel of the Medical Department in all branches, wherever serving.

The Office of Personnel, SGO, is preparing a new master card to be used for every Medical Department officer, female or male. All will be carried on this new card. It is expected that the cards should be out of the printer sometime within the next three (3) or four (4) weeks and the clerical personnel in the office will be in the process of transposing this information to these cards. We feel sure

that when these cards are finally developed our office should know everything there is to know about an officer to enable the office to make the proper assignment on him.

I have been very much impressed with the fact that personnel seems to have developed in every discussion so far at this conference. I can assure you that it is the desire of the Office of Personnel to cooperate with each of you in your individual problems so that the Medical Department can maintain the prestige which it has gained.

The Assignments Branch of the Office of Personnel is getting a considerable number of requests for changes of station for personal convenience. To show you an idea of our workload on this, I will give you a few figures on permanent changes of station. From 11 June through 12 July 1946, there were 1484 moves plus 300 dentists commissioned and brought to duty, 1640 ASTP students moved in and out of Brooke Army Medical Center Field Service School for a total of 3,424 moves exclusive of overseas movements, TDY assignments and the assignments of 800 Navy dentists brought to duty for the use of the Army. So you can see that Major Moore is kept very busy and more requests for transfers for personal convenience only increases this workload.

There has been some discussion and disagreement on the War Department level permanent change of station system from the armies. Several of the armies have objected strenuously to the War Department controlling it here in Washington. It is under the 90-day consideration and General O'Hare of the Central Officers' Assignment Group feels that we are absolutely justified in having this control here in Washington and you can see why this is so necessary. We have to know where the officer is, where he is going, and what he has done.

It was necessary during the War to decentralize to subordinate agencies. Now that the War is over this should be centralized both from the standpoint of the career of the officer and the amount of money we have available to move an officer on.

DISCUSSION:

Question 1: In view of the fact that the army commander has no control over personnel assigned to professional activities at Class II medical installations, what authority does the army surgeon have, particularly in reference to assignments, reassignments, and transfers, when acting in his capacity as a representative of the army commander?

Answer : None.

Question 2: The specialists critically needed in the Second Army are: ophthalmologists; radiologists; surgeons qualified to be chiefs of surgical sections; medical laboratory officers, and internists qualified to be chiefs of medical sections. Numerous requisitions have been submitted to the War Department for these specialists which have not been filled. Can we expect that they will be filled?

Answer : The Personnel Service is endeavoring in every way possible to make an equitable distribution of critical MOS's, particularly 3 of those mentioned (ophthalmologists, radiologists, and chiefs of services). At the present time, there are 242 Regular Army Medical Corps officers in refresher professional training. We have already started to assign the top group where they are critically needed, however, the situation in regard to this group of specialists will continue tight for sometime to come. Your attention is invited to the information copy of a letter that was sent to all general and regional hospitals in reference to the freezing of key personnel. Attention is also invited to the provisions of paragraph 10, present separation criteria.

Question 3: Medical Administrative Corps officers are becoming scarce in the Second Army. What is the policy of The Surgeon General in regard to the use of Medical Administrative Corps officers on non-medical jobs? How arbitrary can we be in transferring MAC officers from such jobs?

Answer : The policy of The Surgeon General in regard to the use of medical officers on non-medical jobs is that they should be withdrawn and assigned medical jobs at the earliest practicable date. As you know, the situation as regards MAC's is critical but this situation will be eased somewhat by the recall to active duty of 400 MAC officers and the integration into the Regular Army of 491. The quota is 503, and since we still have 44 on the eligible list, the quota will undoubtedly be filled. However, all Medical Department personnel should be withdrawn to come under the direct supervision of The Surgeon General. This is in accordance with the general policy throughout the Army to return officers to the control of their respective branches.

Question 4: Certain officers within the Second Army have been integrated into the Medical Department of the Regular Army. Can we expect that such officers will be allowed to continue in their present assignment or should we expect early transfers?

in checking these reports for accuracy and sending out letters asking for corrections. In many instances the army surgeon receives a request from the Statistical Division, SGO, for clarification or correction of a report when the clarification or correction has already been made by this office or by the originating installation at the request of this office and forwarded to The Surgeon General. Can anything be done to reduce this duplication of work? Another example is the WD AGO Form 8-19 - "Report of Medical Department Personnel". Is there any reason why a separate report must be made out for Veterinary personnel?

Answer : This office feels that the 8-19 report and 8-164 rosters are essential for the efficient operation of this office. As the number of general hospitals is reduced and the personnel situation becomes more stabilized, it will not be necessary for the Class II installations to submit an information copy of their 8-19 and 8-164 to these army surgeons for their information.

Question 7: Medical personnel activities are conducted in the Medical Section at this Headquarters and excellent cooperation with G-1 has been maintained. In one way or another, medical personnel must be handled in the Medical Section. The question arises as to whether a Personnel Sub-section should be shown on organization charts, or should the personnel activities be camouflaged under the Administration Sub-section?

Answer : While it is recognized that G-1 is responsible for the personnel policies within the army area under the control of the army commander, it is also recognized that medical personnel should be moved only on the recommendation of the surgeon. Therefore, it is felt that a personnel section of the army surgeon's office should be set up if permission can be obtained from the army commander.

Question 8: What has been accomplished, or is contemplated, in connection with appointment of Regular Army Warrant Officers, Medical Department?

Answer : Your attention is invited to AR 610-1010, paragraph 4, reference to the Warrant Officers medical supply. There is at the present time being prepared an examination for Warrant Officers in this category. The date of release has not been determined to date.

Question 9: Is there any general policy as to the proportion of enlisted personnel of the Medical Department to be replaced by civilians in regional and station hospitals?

Answer : There is no general policy as to the proportion of enlisted personnel of the Medical Department to be replaced by civilians in regional and station hospitals, however, we are asking War Department authority to have as a minimum seventy per cent (70%) enlisted personnel in all hospitals. This is desired because these enlisted men represent the only reserve available to Medical Department in case of an emergency.

Question 10: What various specialties are to be represented among civilian professional consultants? Will the policies permit their use on a part-time basis once or twice a week or for consultation for individual cases?

Answer : Your attention is invited to the letter, subject: "Teaching Consultants" with reference to medical and surgical consultants.

Question 11: What is the policy as to the appointment and assignment of negro Medical Department commissioned, including nurses, and enlisted personnel?

Answer : It is not the intention at this time to commission any colored medical officers or nurses. The percentage of enlisted colored should not exceed 10% at any given installation.

Question 12: WD Circular 138 is vague on assignment responsibilities and authority of Army Ground Forces and the War Department. As now written, Army Ground Forces can order re-assignment of individuals by MOS from station hospitals to Army Ground Force type units at the same station, as no permanent change of station is involved. It is therefore, recommended that the initial classification and assignment of medical officers to Army Ground Force type units be made only by the Central Officers' Assignment Group.

Answer : This question requires only local decision and these assignments should be made upon the recommendations of the army surgeon only.

Question 13: What does The Surgeon General expect of the army surgeon at Class II medical installations to include: preventive medicine functions; professional consultant functions;

nursing service functions; dental functions and personnel administration?

Answer : The Surgeon General desires that the army surgeons assist in coordinating the duties delegated to the army commanders by WD Circular 138, 1946 with the commanding officers of Class II Medical Department installations and to carry out an over-all program for the proper utilization of consultants in both Class I and Class II Medical Department installations.

Question 14: Since general hospitals have ASU and TSU units, is it intended that non-Medical Department personnel assigned to the ASU be included in the WD AGO Form 8-19 (Report of Medical Department Personnel) and WD AGO Form 8-164 (Roster of Appointed and Commissioned Personnel) submitted monthly by the ASU?

Answer : Yes! All personnel stationed or assigned to a Class II installation should be included on your 8-19 and 8-164 reports.

Question 15: The time required to secure permanent change of station orders through the Central Officers' Assignment Group is excessive. Could not steps be taken to shorten this time?

Answer : Central Officers' Assignment Group is making a study and every possible delay is being eliminated. It will take some additional time before all of the kinks have been ironed out.

Question 16: When will the next integration of Medical Department officers into the Regular Army occur?

Answer : The next integration of Medical Department officers is in the process of being firmed up, but the definite date has not been set at this time.

Question 17: How will Regular Army Medical Department officers rank with those recently commissioned in the Regular Army?

Answer : An officer appointed under the provisions of Public Law No. 281, 28 December 1945, will rank immediately below officers in the same grade already in the Regular Army with an equivalent for next greater length of service.

The following general discussion was entered in by the conferees:

GENERAL BAYLIS: Take at Fort Benning, there is an officer on duty with one of the tactical units. This should be a good time to rotate that officer to a hospital and put someone in the hospital with the unit. Do I understand that that is the policy within the Army because it does not involve an actual change of station?

COLONEL KINTZ: This office would want an information copy of any order issued because the office would have to keep a record of professional assignments on master cards. The office will need to know the information so that we can follow the professional career of the officer.

COLONEL WILLIAMS: In transferring personnel to a tactical unit the Ground Forces directed a change of men with certain MOS to these units. These men were lost to the army surgeon as they then came under the jurisdiction of the Ground Forces.

GENERAL BAYLIS: The station complement lost the men.

LT. COL. PERKINS: You are called upon as army surgeons to supply certain qualified key personnel from the only available source. If they were not available you should come into this office and we will help out.

COLONEL WILLIAMS: The point I am making is that there were vacancies in the tactical units and the Ground Forces knew it and these units had been stripped of medical people when the area was called on for T/O organization allotment personnel which had to be taken from the station complement to fill the need.

LT. COLONEL PERKINS: Reserve units are being filled with personnel as they become available from Brooke. There have been delays and we are doing everything possible to shorten the time interval because it is difficult to operate in the field when there are delays.

COLONEL RICE: Is there any way to expedite these matters? We have some orders on people from our area in for about three (3) weeks. In sending these in the orders are requested through G-1. They claim they are sent on immediately. Will a copy of the recommendation sent to the SGO expedite the matter?

MAJOR MOORE: Copies of orders are being sent on date of issue to G-1's of armies. The overload of work has now been processed and all requests for orders are now processed within 48 hours.

COLONEL RICE: What about the second integration?

COLONEL SMITH: The date for the integration has not been fixed but there will be another in the very near future.

GENERAL BAYLIS: Are we gaining ground or losing ground on incoming officers to the Regular Army?

LT. COLONEL PERKINS: Right now we are just about even and we hope to gain on the next integration.

COLONEL WILLIAMS: At the New Orleans Port of Embarkation of the Fourth Army Area we have requests for services of surgeons aboard army transports. Are we carrying out our role in recommending that the Port Commander discharge this responsibility?

LT. COLONEL PERKINS: You would have to call on the army surgeon for these people. The only way for the additional number of officers to be available there as I see it is to have at least six (6) over assigned to the port hospital on call of the port commander in order to assign them to boats in case of emergency. This has been discussed with Colonel Kojassar of the Transportation Corps Personnel Section and he agrees that the above is the best feasible way of clearing this situation.

GENERAL KIRK: The Transportation Corps has always played ball right along and their hospitals have been taken away and turned over to the army so personnel must be made available.

COLONEL KINTZ: Relative to General Baylis' question as to whether we are gaining ground or losing our figures for the Regular Army show about a 200 loss and the number integrated just about this same thing.

I will now ask Major Moore of the Assignments Branch to give an explanation of some of the procedures there and what causes delays, etc.

MAJOR MOORE: During the first three (3) weeks of the COAG plan we were vague, as was the AG on some of the procedures to be followed, and there were delays. Now, some of the cases that come today are processed and out of the office within 48 hours. If they are routine it is possible that they are out the same day. In the SGO processing is done the day the case is received and it is back to the AG and the delay comes in getting the orders from TAG. The request comes to the AG or G-1 who in turn forwards it to the COAG. Most requests contain every arm required. When it reaches the COAG it is broken down and sent to each branch concerned. When it reaches the Office of The Surgeon General, action is taken and it goes back as an individual case. There has been a delay in the message center from TAG to us. We have overcome this by using a special messenger service. We are now furnishing tissue copies to the army surgeons of all requests for orders on personnel so that you will know the request has gone to the AG and the approximate date. These orders are usually out within two (2) days of request although I have heard that orders issued on 1 July have not reached stations until 10 July.

Several of the armies have sent in reports that asked orders on men in June or July and have not received these orders as yet. All these reports were checked and it was found that these were those on which some complication had occurred, such as being advised to hold up on orders, etc. As an example, today a request for orders will come in and tomorrow we will have a revocation or an amendment. Yesterday afternoon we received from one army area a TWX dated 16 July asking for orders, later another TWX dated 16 July asking us to revoke orders and still later a request in writing dated 16 July to assign the man somewhere else. Now we will have to go back to the army to find out where to assign this man. Cutting revocations and amendments will certainly speed up this present processing system.

GENERAL WALSON: You can expect criticisms as long as there are delays in orders because if a man is particularly needed at a station we just have to put him on TDY at that station until the order comes through. Will a man lose advantages of a permanent change of station status if he is put on TDY first?

MAJOR MOORE: This will depend on his movement prior to the date of his PCS order, that is, if he moves dependents, etc., before that date he will lose those advantages.

GENERAL BAYLIS: In view of the curtailment of travel funds, this would use up temporary duty funds we have to meet a situation which will be covered later on to cover this emergency situation. It causes use of the army funds which the War Department has allotted and the army does not like it. As a matter of fact, we have been issued instructions that this can only be done in cases of emergency. At the present time there is a situation at Fort McPherson, Georgia. Orders have been requested sometime ago, but have not yet come through on one of the men there. When we reach the shortest period of time in which actual moves can be assured and get actual receipt of orders, the better off the Army will be.

COLONEL KINTZ: This is not particularly applicable to the Medical Department only. Army commanders have complained and are using this as a basis for objections to centralized control.

GENERAL WALSON: They are building up plenty of information and criticism, too.

GENERAL KIRK: You army surgeons should know two (2) months ahead when a man is going to be moved, not twenty-four (24) hours beforehand. If everyone knows when certain people will get out then you should be able to anticipate these vacancies and ask for replacements. The new chiefs of services and sections will probably be ASTP men.

GENERAL BAYLIS: This is all very well, but we have no way of seeing emergency moves coming especially when requests have come in and they aren't filled and we don't know when they can be filled.

COLONEL KINTZ: We can tell you about this.

GENERAL BAYLIS: All right, I have a request in for August. Can the information on this be supplied?

COLONEL KINTZ: Colonel Leech, what about that?

COLONEL LEECH, Office of Personnel, SGO: Yes sir! We can make a good estimate right now as to when this personnel will be available.

GENERAL BAYLIS: I am glad to know that. I shall be up to see you.

MAJOR MOORE: If you will send emergency requisitions direct to the office we can handle them as emergencies and the matter will be expedited.

GENERAL BAYLIS: From now on I shall send a TWX or telephone this information in and it will help a lot.

COLONEL RICE: What is done about a requisition for personnel which later on is sent in as a duplicate request with additional names added to the original list.

MAJOR MOORE: There is quite a bit of duplication, but the requests of the previous month are void on the 10th of the subsequent month and this automatically takes care of the situation.

GENERAL WALSON: What about the requisitions sent in on the 10th of the month?

COLONEL KINTZ: Work is started the minute requisitions are received.

GENERAL WALSON: Do you plan on filling a requisition right then? We have been sending in an information copy of our requisition to the SGO.

COLONEL KINTZ: We plan on filling these as soon as possible and the First Army is the only army that is sending in advance copies on requisitions and these are a help. I would also like to say that in the near future there will be a Category VI, VII, and VIII, for recall of officers back to active duty. These officers may sign a Category VI, where they state that they will remain on active duty for 12 months, a Category VII, for 18 months, and a Category VIII for 24 months. Further, in reference to requisitions, it is planned that when the

Central Officers' Assignment Group finally gets more stable requisitions will be dispensed with and a running inventory of all officers will be maintained.

GENERAL BAYLIS: On information as to when an officer is available an officer is usually granted some leave and the army surgeon has no knowledge of the amount of leave he has been granted the surgeon is still up against the emergency situation.

GENERAL WALSON: What about an officer on terminal leave desiring to take a refresher course? At the time of his going through the reception station he is asked if he wants such a course and says he does not. Later on when he finds conditions are not to his liking he asked for refresher training. Do we give it to him?

COLONEL KINTZ: This would mean calling a man back to duty for 12 weeks and then separating him. If he is willing to sign a Category VI statement and come back on duty for 12 months there could be no objection, but otherwise, it would not be good economy.

GENERAL WALSON: Well, I don't see where the Army is getting anything out of it.

GENERAL BLISS: Refresher courses were set up for the good of the Army.

GENERAL BAYLIS: What is the War Department policy as it exists on this now?

COLONEL KINTZ: The period of time for refresher courses has been extended to 31 December 1946 for AUS, Reserve, or ASTP officers who may be put on refresher training for 12 weeks.

GENERAL DENIT: What about the Regular Army interns?

LT. COLONEL SMITH: To date, 53 applications have been received. We have accepted 20. We would like to leave this open and would like to get a lead on some good intern material. Theoretically this time was closed on 8 July, but I see no reason as to why it could not be extended.

GENERAL BEACH: What does it take to put it before them?

LT. COLONEL SMITH: Most of the interns contacted had already signed up for their internship for the following year.

GENERAL BEACH: Why not ask the deans of the medical schools if this can't be presented to the students by the army officers.

COLONEL DUKE, Chief, Education and Training Division, SGO: At a meeting of the Hospital Association it was agreed that all acceptances for internships must be made by 1 July. The great majority of fourth year medical students will have already accepted their internships and will have been accepted by the hospital. Frankly, I don't think we were at all late in getting our information out.

GENERAL BEACH: Would it be unethical to get the youngsters to try to change their minds?

GENERAL WALSON: It is my understanding that this information was not forwarded to the students.

LT. COLONEL SMITH: I believe that it is true that information was not spread well, certainly the married boys were very much interested from the pay and allowance standpoint.

GENERAL KIRK: I think each surgeon should send a good man out to the medical schools to talk up Army internships.

GENERAL WILLIS: We can get them out of the classes at Brooke, if the fact that one internship doesn't preclude them accepting another internship, they can be picked right out of the ASTP's.

GENERAL KIRK: What about the dental internships?

COLONEL KINTZ: The paper on dental interns has gone in but there has been no reply.

GENERAL BAYLIS: In going out talking about the internships, wouldn't it do more harm than good?

GENERAL DENIT: You should talk about next year's program and answer any questions about this year's program.

GENERAL BLISS: We should have started sometime ago and had the surgeons go to the schools and talk about it.

COLONEL KINTZ: A very vital point of interest has been the integration program. I will now call on Lt. Colonel Smith to bring you up to date on this information.

3. Integration of Medical Department officers into Regular Army and Army interne program. -

Lt. Colonel Larry Smith, Assistant, Office of Personnel, SGO, made the following statements. The War Department finished the first integration of Regular officers on 28 June 1946. The chiefs of

branches and services now have an opportunity to make any necessary adjustments on the Regular Army integration in the time remaining up to 28 August 1946 which is the expiration date of Public Law 281. The Medical Department was able to fill the quota in all corps except the Medical Corps. There were 925 vacancies in the first integration.

The Surgeon General set up a board of ten (10) Regular Army officers representing the various branches and divisions of The Surgeon General's Office. This board of officers then reviewed each individual case and made recommendations that the applicant be placed on the eligible list for a Regular Army commission or rejected. Each case was then reviewed by the Central Medical Department Board. This board either concurred in the recommendations, sustained rejections, or referred the case back for further consideration by The Surgeon General's Officer Selection Board. Each case then went to the ASF Review Board, which again considered each case, and concurred in the action taken thus far, or returned the case for further review. From here a case went to the Secretary of War's Board which again reviewed the action taken and made pertinent recommendations.

The vacancies were broken down into the following quotas: 210 vacancies for the Medical Corps, 128 for the Dental Corps, 84 for the Veterinary Corps, and 503 for the Pharmacy Corps. The original quota for the Medical Corps was 500, but due to the lack of a sufficient number of qualified applicants, the additional 290 vacancies were given to the Pharmacy Corps.

The Medical Corps had the lowest degree of selectivity for all corps of the Army. The Surgeon General received 508 applications for the Medical Corps. He approved 205 of these for commission in the Regular Army. The War Department offered commissions to 191. Of the number who were offered Regular Army commissions, a total of 163 have replied. Thirty-four have declined Regular Army commissions. This easily gives the Medical Corps the highest ratio of declinations as four per cent (4%) is the overall percentage rate of declinations, Army-wide.

We received 384 applications for Dental Corps commissions, of which 185 were approved. The War Department offered commissions to 127. Replies have been received from 105 of these cases. Sixteen applicants have declined.

Two hundred applications were received for the Veterinary Corps, of which 139 were approved. The War Department offered commissions to eighty-seven (87). Replies have been received from seventy (70) of these. Six (6) have declined.

There were 1,923 applications received for Pharmacy Corps commissions, of which 558 were approved. The War Department offered commissions to 491. To date, replies have been received from 413.

Twenty (20) have declined. 739 Pharmacy Corps cases were rejected outright andit is not anticipated that these cases will be reconsidered in the future integration. 693 Pharmacy Corps cases were tentatively approved and will be reviewed when the new quota on the next integration has been announced. Of the cases rejected by The Surgeon General, very few, if any, will be reconsidered in a future integration.

The vacancies that exist in the Medical Corps, however, will not be lost to The Surgeon General as he will be able to recommend qualified men to fill them, and it is anticipated that vacancies will be carried over into the next integration. It is expected that in the next integration program ASTP students who have now been commissioned and placed on active duty and were not eligible for the first integration will become a prime source of Medical Corps officers in the next integration.

It is anticipated that in the near future the War Department will announce the new integration program. This proposal has been approved by the House Military Affairs Committee and passed by the House of Representatives. It has passed the Senate Sub-Committee on Military Affairs and at the present time is being considered in the Senate Military Affairs Committee. Indications are that favorable action will be completed before Congress adjourns.

The War Department would like to integrate about half of the 25,000 requested increase for the second integration and wants to integrate the remainder over a period of years.

The integration has not been the answer to filling the Medical Corps for the Army. The Veterans Administration has offered: (1) higher pay; (2) continued medical training which has been approved by the various specialty boards; (3) no foreign service; (4) locations agreeable to the individual doctor, and (5) adequate quarters. These advantages have made it difficult for any medical officer considering Government service to choose the Army for a career.

Greater financial inducements will have to be made before the Army Medical Corps can come up to full strength. Whether this is effected by a general overall depression in the nation, or an increase in pay, remains to be seen. The following table sums up the action of integration:

Corps	No. cases received	Vacancies	Approved by TSG	No. Officers commissioned	Replies	No. declining
MC	508	210	205	191	163	34
DC	384	128	185	127	105	16
VC	200	84	139	87	70	6
PhC	1923	503	558	491	413	20

And now, a further word on the intern situation for the coming year. Fifty-three applications were received and twenty (20) of these were accepted for internships beginning 1 July 1947. Eleven declined and eighteen (18) were rejected. Four (4) failed to complete their applications. It is believed that applications for internships should be kept open to enable individuals who are interested in the Army as a career to avail themselves of the opportunity. The army surgeons can give valuable aid to this program by contacting senior medical students and giving information and publicity to the advantages of an Army internship to the medical schools.

GENERAL DENIT: We will now call on General Smith, Chief of the Dental Division, for some information relative to his situation.

4. Dental personnel and the central dental laboratory. -

Brigadier General Thomas L. Smith, Chief, Dental Consultants Division, SGO, made the following statements:

I would like first to give you the dental personnel situation as it is at the present. As you no doubt know the separation criteria for dental officers has been higher than for other branches. A great deal of repercussion and criticism were offered about this situation from numerous sources, including congressional. In an effort to correct this situation and get the criteria down commensurately, numerous steps have been taken. At first a call for 750 volunteers for the Dental Corps was made. Only fifteen (15) applications for commission was the response to this call and it was evident that more drastic steps would be necessary. The Navy Department was on the verge of releasing several hundred dentists with much shorter service than was required in the Army. Accordingly, arrangements were made with the Navy to transfer 800 dental officers from the Navy to the Army. This allowed the criteria to be dropped from thirty-nine (39) to thirty-six (36) months active duty service. It is a rather unusual circumstance to have 800 Naval officers detailed for duty with the Army, and I will speak of this a bit later.

This was not regarded as a satisfactory separation criteria compared to other branches. Since December 1944, only 150 Dental Corps officers were commissioned into the Army. A great number of dentists had graduated previously, had received their professional education at government expense (ASTP), and had not served in a commissioned status in the Army. It was decided to either bring these dentists into the Army as privates through Selective Service or give them an opportunity to apply for commission. Accordingly, a call was placed on Selective Service for 1500 dentists. The response to this action has been quite satisfactory. Approximately 650 applications have been received in this office for commission in the Dental Corps to date, and these applications

are coming in at the rate of about fifteen (15) per day. In addition to these two (2) phases, we are in the process of integrating into the Regular Army approximately 128 officers. So it can be seen that we are in the process of releasing and taking in approximately 2400 officers in the Dental Corps, which means we are having almost a complete turnover of this personnel in the Army. Our personnel section in the office is very busy these days with this job.

The lowering of the separation criteria is dependent to a great extent of the receipt in the overseas theater of sufficient officers at first. You can see that it wouldn't do for us to announce a lower separation criteria and start separating officers in the States before we had sufficient number overseas for them to start a like separation. So, any announcement of a lowered criteria will have to wait until the newly commissioned officers have had the basic course at Brooke and can be shipped overseas. One hundred (100) Naval officers and 500 newly commissioned Army officers enter the July, August and September classes and will go immediately overseas, anticipating a September 1 reduction in service criteria to thirty (30) months. Three hundred sixteen will be placed in the September class for overseas movement, anticipating a reduction in the criteria from thirty (3) months dovm. The newly commissioned officers above this number and up to the 1500 will be used in the zone of interior with our ultimate separation criteria projected as twenty-four (24) months. This, of course, cannot be announced yet and is entirely dependent on the Selective Service forcing enough to apply for commission.

It was planned that these new officers could be commissioned within three (3) weeks of their application, but in some instances that schedule is not being maintained and the dentists are being inducted as privates into the Army. The induction boards have instructions to defer their induction for thirty (30) days. I would like to call your attention to the fact that paragraph 7b (1) and (4) AR 605-10, dated 28 May 1944, for those dentists who have been inducted into the Army as privates, has been waived per AGO letter - AGSO-A-A 210.1 (13 June 46), subject: "Procurement Objective for the Medical Corps, Army of the United States (DO)," to The Surgeon General. This provides for the immediate commissioning of these dentists and compliance with such orders as may be issued. We are very anxious that this will be adhered to as this group of officers will be a source for the increase of our Regular Army Dental Corps. If they do not receive this consideration it will be rather distasteful to them in the very beginning.

Now, to go back to the Naval dental officers, who are detailed to duty with the Army. Instructions and directives will be released from the War Department in the very near future regarding this personnel. I can answer a few of the questions that are bound to arise now. These officers will continue to hold their commissions in the Navy and wear the Navy uniform. Administratively, they will be treated as if they were Army officers, in such procedures as: courts-martial jurisdiction, promotion, leave, etc. Agreements have been made with the Navy regarding such matters as: hardship, etc., which will be handled on a War Department level. A case which comes within the purview of these agreements will be referred immediately to the Naval Board, and, if this board regards the case as sufficiently justified it will make a request on the Army to return the officer to the Navy for separation. In general, however, these officers will be treated exactly as if they were in the Army, with the exception of the uniform. They will receive their pay from the Army disbursing officer.

Ceilings on dental officers is today being based in the zone of interior on two (2) dental officers per 1,000 military strength, with an additional dental officer for each 1,000 trainees. Dental officers assigned to hospitals and those serving in administrative capacities are in addition to this number. This basis can be used in figuring authorized dental officer strengths for camps, posts, and stations. The authorized ceiling of dental officers for overseas duty has recently been increased from 1.1 to 1.25 officers per thousand troop strength. It is anticipated that the greater portion of the dental treatment required for troops will be completed in the states prior to overseas movement, consequently, less dental personnel are needed in the overseas theaters. Your cooperation in this respect is requested as (at this time) we would rather have requisitions for more dental officers than we can fill, so that when the personnel becomes available there will be no delay in making the assignments.

The dental internship program has not been firmed up as yet. It is expected, however, that we will have dental internes back in the service in the fall of 1947. This will be the first time dental internes have been on duty in our hospitals since the beginning of the War. We would like to be able to offer this program to the senior class this year and have them assigned by December of this year. We have been able to place a few junior officers in the long term specialized training program at civilian institutions this year. These courses will be continued if possible, as personnel trained in the several specialized branches of dentistry is badly needed by the Army.

There is no change planned for the operation of our central dental laboratories. The one at St. Louis is to move from Jefferson Barracks to the St. Louis Medical Supply Depot in the near future. These installations are ordinarily very busy and in accordance with Section IV of WD Circular 21, 1946, it is hoped that all of the larger installations

will be able to provide their own laboratory service. It is probably all right for the smaller posts, camps and stations to install and operate their own laboratories as well. The central dental laboratories are provided for taking care of those installations which have no laboratory service on the post, and for over-flow from other posts. There are still provisions for this service to be provided by civilian laboratories, but this must be kept to a minimum. Some very large bills in this respect have been paid in the past.

DISCUSSION:

GENERAL WALSON: In visiting various posts and interrogating various surgeons I find that the dental officer prefers to do his own work rather than send it to the central dental laboratory. I have wondered that since this is laboratory work, would it be practicable to get this work done at a laboratory capable of handling the work instead of sending it to the central dental laboratory?

GENERAL SMITH: Local work should be encouraged.

GENERAL WILLIS: At the Central Dental Laboratory at Brooke they are not overworked and they don't have enough work to do. The maximum time a case takes at Brooke is forty-eight (48) hours plus travel time.

GENERAL SMITH: This is a bad item (travel time).

GENERAL WILLIS: Air mail is used whenever possible.

GENERAL BAYLIS: Is it contemplated that Class III installations (Air Corps) will set up their own laboratories for this work? What progress has been made on the increase in allotment to army areas of dental officers? We have an allotment coming from the War Department authorizing only so many Dental Corps officers per sub-allotment to go out in numbers to the posts. We have put in through channels a request for additional dental officers.

GENERAL SMITH: Some of the Class III installations are already doing their own laboratory work and this is to be encouraged. As to the allotment of dental officers in army areas, I would suggest that this request be started at each post, camp and station if the allotment is not sufficient to care for the dental treatment. This request should contain all the reasons why the allotment is not sufficient, that is, well substantiated justification, without even mentioning the two (2) per 1,000 troop strength basis. Certainly this request should contain information as to the military strength of the post, camp or station. It is suggested that these requests be consolidated at army headquarters and forwarded to the War Department if it is considered that an overall increase of officer strength will be effected by this increase of dental officer personnel. I think such a request to the War Department will

receive favorable consideration.

Question 1: What is the policy of The Surgeon General concerning the number of dental officers per 1,000 troops at posts, camps and stations? How many additional dental officers will be allotted per 1,000 troops in replacement training centers or pools training men for overseas service?

Answer : Planning is based on the allotment of two (2) dental officers per 1,000 in posts, camps and stations in the zone of interior, with allowance of one (1) additional dental officer per 1,000 in training centers. This does not include allowance of other installations located in army area but not under control of army commander, such as general hospitals, etc.

Question 2: What does The Surgeon General expect of the army surgeon at Class II medical installations in regard to dental functions?

Answer : The Surgeon General expects the army surgeon to provide all medical (which includes dental) service at all Class II installations except general hospitals.

Question 3: Are plans being made to change the present system of requiring all dental prosthetic work to be sent to a central dental laboratory for fabrication?

Answer : War Department Circular 21, 1946, states that all general hospitals and posts, camps, and stations with a military strength of 10,000 or over will furnish their own laboratory service, with the provision that each of these stations is authorized to forward cases to the central dental laboratory serving its area when local facilities cannot meet the demand.

5. Procedure of determining officer ceilings.

In reply to a question with regard to procedure of determining officer ceilings, Mr. Cogan, Chief, Resources Analysis Division, SGO, made the following statements:

Formerly the allotment of personnel was made by the War Manpower Board and sub-allocated to the service commands by ASF. The service command ceilings for Medical Corps officers were based on recommendations of The Surgeon General. The ASF function has now been taken over by the Office of Organization and Training, WDGS. The present procedure has not been completely ironed out, however, a paper was

forwarded to Organization and Training, WDGS, recommending Medical Department officer ceilings for the army areas for 30 September 1946. These recommended ceilings are based primarily on WD Circular 209, 1944. In the case of Dental Corps officers, the ceilings are based primarily on troop strength. Because of the shortage of Dental Corps officers, dental officer ceilings were formerly calculated on the basis of two (2) per 1000 for total ZI troops. The presently recommended ceilings are calculated at two (2) per 1000 troops plus one (1) additional dental officer per 1000 troops in basic training, and an additional allotment for general hospitals in accordance with WD Circular 209, 1944. In addition, dental officer allotments are made for training centers and laboratories. This will result in a ratio of dental officers to troop strength of approximately 2.7 per 1000 for the ZI, 1.25 per 1000 for overseas, and a world-wide average of two (2) per 1000. These are the ceilings as recommended by The Surgeon General. The ceilings you will get will depend upon the availability of personnel and the decisions of the War Manpower Board and Organization and Training, WDGS. At present, we are getting in a considerable number of dentists. This might create a temporary surplus until these dental officers are assigned to their positions and the officers with longer service are separated. The thing to consider is that it is much better to have an officer who will remain in service for at least two (2) years, than one who will remain in service for only two (2) or three (3) months. So, when these newly commissioned officers are assigned to you, I would suggest that you accept them and declare surplus those officers with longer lengths of service even though they may still have one (1) or two (2) months service to perform.

DISCUSSION:

GENERAL BAYLIS: Does this include Medical Corps?

MR. COGAN: Ceilings for Medical Corps officers are based on WD Circular 209, 1944. One of the difficulties is that recommendations are made considerably ahead of the period when the ceilings become effective, and must therefore be based on anticipated bed requirements. These may vary considerably from actual bed requirements at the time ceilings become effective.

GENERAL BAYLIS: Do you use WD Circular 389?

MR. COGAN: WD Circular 389 details WD Circular 209 by MOS and grade, and agrees with it in totals by corps.

GENERAL BAYLIS: In a 900-bed hospital those medical officers might be able to take care of the sick in the hospital if they didn't have all the administrative work which evolves itself into the fact that they are about 30 per cent short, exclusive of those assigned to the technical unit.

MR. COGAN: In addition to 209 requirements, the proposed ceilings include requirements for dispensaries, laboratories, and miscellaneous activities. WD Circular 209 applies to hospitals only.

GENERAL WALSON: Every hospital has a different yardstick.

GENERAL HAGIN: The War Manpower Board only wants to allot on the number of beds available.

GENERAL BLISS: The War Manpower Board surveys every hospital in the zone of interior, sets up tables based on what the commanding officer says he needs and what War Manpower Board says he needs. The result constitutes the ceiling.

GENERAL BEACH: The Manpower Board takes into consideration the miscellaneous services in the hospital.

MR. COGAN: The War Manpower Board sets allotments on total officers. The decision as to how many officers of each corps to be alloted to the army areas is that of Organization and Training, WDGS. It was ascertained on 31 July that G-3 did not take over this function from ASF. This function is now the responsibility of G-1. The Director of Personnel and Administration, WDGS, is presently considering the question of sub-allocation of personnel by corps, but as yet no sub-allocation to armies has been made. Since the last service command conference, ASF (now, Organization and Training, WDGS) has gone along with our recommendations as far as male officers are concerned; they did not go along on nurses. The conclusion must be drawn that if the number of Medical Corps officers alloted to an army area, up to the present time, is inadequate, the fault is either with the manning guides or with the lag between the time the ceilings were recommended and the time they became effective. A committee has been set up to review the manning guides, and any recommendations and suggestions with regard to these guides will be appreciated.

GENERAL BAYLIS: Ceilings are controlled by availabilities of total officers, and ceilings should be based on the availabilities of each corps and then totaled into total officer ceilings, and the information as to each corps should be forwarded to the army area.

MR. COGAN: Availabilities control the ceilings for some of the other corps, but ceilings for Medical Corps officers have been based on requirements since sufficient numbers were available to meet such requirements.

COLONEL RICE: Does the Army get a bulk authorization with breakdown of Medical Corps, Dental Corps, and Veterinary Corps, etc., for all officers.

MR. COGAN: It is a bulk authorization until it gets to G-3, who breaks it down into an allotment to the armies.

COLONEL RICE: It is a monthly fight to get medical personnel to run installations.

GENERAL BAYLIS: When the Headquarters, Seventh Army suballots officers they indicate in there for the regional hospital so many Medical Corps, Army Nurse Corps, and BI, then set up station complement and set up so many MC, DC, Nurses, etc. This is the group the station commanders can play with. There has been considerable difficulty in retaining the quota which is needed for station complement but they will howl to high heaven if the clinic and the station complement cannot run its business properly.

GENERAL DENIT: General Baylis, write this information in and we will see what can be done about it.

COLONEL ROGERS: I would like to know if something can be done about the new efficiency report?

GENERAL KIRK: This report is the personal desire of the chief of staff and the War Department psychologist.

COLONEL KINTZ: This new efficiency report was made up by Dr. McComb of The Adjutant General's Office and has the approval of the Chief of Staff.

DISCUSSION:

Question 1: What is the policy of The Surgeon General concerning the number of dental officers per 1000 troops at posts, camps, and stations? How many additional dental officers will be allotted per 1000 troops in replacement training centers or pools training men for overseas service?

Answer : The ceilings for Dental Corps officers recommended by The Surgeon General for 30 September were calculated as follows: (a) Two (2) Dental Corps officers per 1000 troops, (b) An additional Dental Corps officer per 1000 troops in basic training, (c) Additional Dental Corps officers for separation centers as per AGO letter dated 15 November 1945, subject: "Change to Chart I, TM 8-255, 10 September 1945", file: AGMP-M 300.7 (6 Nov 45) SPMDP, (d) Additional Dental Corps officers for general hospitals as per War Department Circular 209, 1944, (e) Additional Dental Corps officers for army area dental laboratories. Because of the shortage of Dental Corps officers, the recommended ceilings for most of the period of demobilization were calculated as described above, but were adjusted downwards not to exceed two per 1000 strength plus one per 1000 additional for troops in basic training for the zone of interior as a whole. This

means that the additional allotments cited above were absorbed within the two (2) per thousand ratio. It must be stressed that the method for computing the recommended ceilings are not necessarily the method that is used by the War Department in its allocation of Dental Corps officers.

Question 2: There is a shortage of qualified nurse specialists in the Second Army. This applies especially to nurse anesthetists, MOS 3445. Most of the nurse anesthetists signed Category IV or V statements and have been relieved from active duty as they became eligible for separation. Can we expect that requisitions for these specialists will be filled in the near future?

Answer : The War Department has just authorized a recall quota of 1000 Army Nurse Corps officers. Colonel Blanchfield has a list of applicants and is therefore, in a position to estimate the number of anesthetists (MOS 3445) that will be recalled to duty under this quota. I also understand that there is a program of training for anesthetists on which Col. Blanchfield can report.

Question 3: The hospitals in the Fifth Service Command were visited recently and a serious problem presented itself in the hospitals in that area. The nurses have been on a straight eight (8) hour schedule of duty, as follows: 7 a.m. to 3 p.m.; 3 p.m. to 11 p.m.; 11 p.m. to 7 a.m. This schedule requires an increase of approximately 25% in the number of nurses required to cover the nursing service. The hospitals in the Fifth Service Command previously had sufficient nurses to use the eight (8) hour day. The present authorization will reduce their number to a point where it will not be possible to maintain that schedule of hours. Most of the hospitals in the Third Service Command had not been able to adopt the eight (8) hour day because the increase in authorization required for that schedule had never been approved by ASF. Sometime in the past, all service commands were requested by telephone from The Surgeon General's Office to use the eight (8) hour day wherever possible, but because there was no directive or written authority to cover this change, the Personnel Authorization Division of the Third Service Command did not approve an increase in authorization for the change of schedule. In order to obtain uniformity and prevent a decrease in morale incident to a change in hours of Fifth Service Command nurses, will a definite policy be forthcoming from the Office of The Surgeon General?

Answer : A request has been submitted to the War Department to change the Table of Allotment of nurses from a one (1) nurse for each fifteen (15) beds to one (1) nurse for each ten (10) beds, with some adjustments for larger hospitals. The memorandum making this request brings to the attention of the War Department that a change to an eight (8) hour schedule of duty for nurses would result in a 25% increase in requirements for nurses. However, no request has been submitted for additional personnel to implement an eight (8) hour schedule of duty for nurses. A recall for 1000 nurses has just been authorized by the War Department. This will meet the requirements under existing ceilings, and might perhaps allow a little better than a one (1) per fifteen (15) bed ratio, but will not provide sufficient personnel either for a one (1) to ten (10) bed ratio or for the implementation of an eight (8) hour schedule of duty.

Question 4: Is there any general policy as to the proportion of enlisted personnel of the Medical Department to be replaced by civilians in regional and station hospitals?

Answer : Yes! It is the desire of The Surgeon General that at least 70% be enlisted personnel. This is necessary because these men constitute the only reserve available to the Medical Department to meet an emergency.

Question 5: Discussion of adequacy and practicability of providing a better yardstick than now provided by War Department Circular 389, 1945, for estimating requirements of medical, dental, and nursing personnel.

Answer : Recommendations for a revision of War Department Circular 209, 1944, and correspondingly War Department Circular 389, 1945, with regard to the female corps has been submitted to the War Department. Appointment of a board to review the adequacy of the above-mentioned manning guides with regard to the male corps is, at present, under consideration.

6. The Medical Administrative Corps officer situation. -

Major B. Aabel, Assistant, Office of Personnel, SGO, prepared the following summary on the Medical Administrative Corps officer situation:

Out of a maximum total of 22,500 MAC's attained in mid-1945 there were on active duty on 1 July 1946 only about 3,300 officers. (About 1800 of these were Regular Army and Category I and II officers.) This was only 15% of that of the corresponding date of 1945, in spite

of the fact that the separation criteria is a full 36 months. With the other arms and services releasing officers with 24-months service, a natural reaction is being manifested by some disgruntled MAC officers through epistolary efforts by their congressmen, the Inspector General and metropolitan newspapers. It is only a few short months ago that the separation criteria for MAC officers was considerably lower than the Army as a whole; the criteria was then reversed in favor of the MAC's, with many officers of other branches attempting to be detailed in the Medical Administrative Corps in order to be eligible for separation at an earlier date.

In order to lower the separation criteria of MAC's to twenty-four (24) months in the immediate future, a procurement authority for 1000 officers has been authorized. These will be obtained by three (3) means: (1) recall to active duty of Reserve and National Guard officers, 170 of whom have already been recalled (an active publicity and direct mail campaign has shown excellent results), (2) the direct commissioning of warrant officers and enlisted men (Pacific and European Theatre C.O.'s have already been authorized to do this), (3) resumption of Officer Candidate School in the early fall months. The sooner this is accomplished, the sooner the separation criteria will be lowered.

We are still sending men overseas who have not had World War II duty in a foreign land. By September we will be sending men over with less than six (6) months overseas duty and who have been back in the States more than six (6) months. Between 15 August and 14 September 100 MAC's will be sent to AFPAC, many of whom will come from army areas.

The utilization of MAC's in other than Medical Department activities is to be deplored and forbidden at this time when we have requisitions for 700 - 800 MAC's from the Medical Training Center, Camp Polk, AGF, AAF, TC, overseas commands, Class II installations, and army areas. MAC's substituting for officers being released with twenty-four (24) months service in jobs other than Medical Department has led to complaints to the Inspector General's Office.

It is interesting to note that 503 officers have just been integrated into the Regular Army, a third of whom were out in civilian life and assigned directly from there and thirty-eight (38) of whom were actual pharmacists. The Pharmacy interests frowned considerably on the use of this corps as a vehicle for this integration, but The Surgeon General has stated that this was an interim measure only. It is planned that, under the new legislation, all PHC, SNC and MAC officers will be commissioned in the Medical Service Corps.

7. The colored and white male enlisted situation. -

Major William Wesche, Assistant, Office of Personnel, SGO, prepared the following summary of the colored and white male enlisted situation:

With the exception of overseas areas and critical category of specialists, the Medical Department installations are not suffering for enlisted men. The April diversion of some 16,000 basics and inductees to medical installations in the zone of interior proved a blessing in disguise, since it made available many men suitable for training and eligible for retention in the service for many months to come. Although instructions were issued to return them to the source from which received on becoming surplus, their release as such was a matter for local decision, and there is no reason why a majority of these men should not have been trained and now on duty as a part of permanent station complements.

Future replacements for losses expected to occur in Medical Department enlisted men will depend a great deal on the present recruiting campaign, and future inductions. The most important source will be Regular Army enlistees and should be expanded to the maximum extent.

The shortage of certain specialists will always be with us. The only remark I can make on this subject is that installations should be forced to select and send men to technicians schools, and not rely entirely on training centers to supply these men. Overseas requirements have priority on the output of training centers and usually few or no specialists are left for zone of interior requirements.

It is not an overstatement to say that the future foundation of the Medical Department depends on the success of the Army recruiting campaign. Its importance to the Medical Department cannot be too highly stressed. The postwar Regular Army will be composed solely of volunteers, and the action taken now will be reflected in future years to come. The importance of this subject should be impressed on every subordinate command and definite policies and procedures put into effect.

Utilization of colored personnel has become a difficult problem. The Medical Department had approximately four per cent (4%) of its strength in colored personnel during World War II, and it is the opinion of this office that a greater per cent cannot be effieiently utilized. Input to Medical Training Centers including enlistees has been in excess of known requirements. Army-wide enlistments have been at the rate of one (1) colored for every five (5) white enlistees, and during the past three (3) months period, of a total of 2445 enlistments for the Medical Department 774 or twenty-four per cent (24%) were colored. To control this problem, the Office of The Surgeon General has recommended

all colored enlistments for the Medical Department be discontinued, input to Medical Training Centers be suspended, and assignments to the Medical Department be stopped. This problem became of such serious proportions that on 17 July 1946 the War Department issued instructions limiting the enlistment of negros to certain designated military occupational specialties. A study is also being made to raise the AGCT score to 80 for all enlistments, which in the course of time eliminates the approximately 63% of the colored and ten per cent (10%) of the white men with low scores.

I. MEDICAL DEPARTMENT TRAINING.....Colonel Raymond E. Duke

1. Professional graduate training program.-

Colonel Raymond E. Duke, Chief, Education and Training Division, SGO, made the following statements:

Before opening the subject of training to general discussion, I would like, very briefly, to outline the original plan for the professional training of Regular Army Medical Corps officers. This plan is based on four (4) documents, copies of which I have just distributed to you. These documents are as follows: the original plan; AR 350-1010; War Department Circular 101, and SGO Circular 17. These form the foundation for the entire professional training program.

During the years of World War II, almost 100% of Regular Army Medical Corps officers were of necessity assigned to staff, command and administrative positions. At the close of the war it was realized that it was of the utmost importance to the Medical Department to get these officers back into professional work. It was realized that there would be a rapid demobilization and that we would lose the highly qualified AUS officers who were currently holding the key professional positions in our hospitals. At the present time we have about one-fifth of the number of specialists in the Regular Army that we need. We have been accused, at times, in this program of trying to specialize every doctor in the Army. That is not true. We will have to have a certain number of specialists, but the object of the entire program is to elevate the general level of the professional qualifications of all Regular Army Medical Corps officers. You have a copy of the program before you, and I believe it is self-explanatory. The procurement of specialists was to be accomplished by four (4) methods. First of all, to get our Regular Army officers, who are certified Board members, back into professional training. Second, to interest highly qualified AUS specialists in the Regular Army and bring them in on our integration program. This was done and we have integrated about twenty-six (26) such individuals. Third, to select those in the Regular Army who have had some training toward their specialty and to get them back into professional assignments where they could continue their training toward their board. Fourth, to select other Regular Army officers for professional training in some specialty. A committee known as The Surgeon General's Professional Training Committee was appointed to supervise the program.

The next step was to get War Department approval of an Army Regulation covering the Professional Graduate Training Program. This is AR 350-1010 and was approved in February of this year. Insofar as this program has heretofore been conducted in general hospitals, it

is very possible that some of the army surgeons might not be entirely familiar with it. I would like to go over it just briefly and point out the more important points. Notice paragraph 1b - The Surgeon General assisted by the Professional Consultants in the various specialties will exercise overall supervision of the program of graduate education and will prescribe the general policies pertaining thereto. Subordinate command surgeons will maintain active supervision of this program at the appropriate Medical Department installation under their jurisdiction. For the army surgeon this will, of course, be the larger station hospitals. Paragraph 2c states that the object of the program is to provide for professional advancement in clinical and research medicine to Medical Corps officers on a competitive basis and the next paragraph assures the maintenance of the health of the Army and provide efficient care of the sick and injured in accordance with the highest principles of medical service by establishing all Army hospitals as teaching institutions. The next paragraph outlines in detail our program on internships. We have internships approved by the Council on Education and Hospitals of the American Medical Association at eight (8) of our permanent general hospitals. The interns are being selected at the present time. The regulation also outlines our residency program in the general and station hospitals. We have asked the AMA approval of some seventy-three (73) residencies in nine (9) general hospitals. To date sixteen (16) of these have been approved and twelve (12) more have been recommended for approval by the inspecting officer of the Council.

Notice paragraph 4 which states that an educational committee responsible for the organization, supervision, and coordination of the medical educational program will be organized at each Medical Department installation engaged in professional activities concerned with the care of the sick and injured. The educational committee is responsible for the overall organization, supervision of the program and the maintenance of such records as are necessary to indicate the accomplishments of each medical officer undergoing training. The committee will assure an equitable distribution of the work to provide well-rounded training and to provide a basis for evaluation of each individual officer's professional development. The regulation provides further, that each medical officer, training in the mixed residency and specialty residency phase of the medical educational program will keep a detailed diary of his activities to include types of cases worked up, investigative work, collateral reading, case presentations at clinical pathological conferences and studies in the basic sciences.

The third document, War Department Circular 101, outlines our consultants program. This was discussed with you yesterday by Colonel Freer. Remember that, the second group of consultants in general hospitals and the eight (8) large station hospitals are teaching consultants. Their primary duty is teaching.

The fourth document, SGO Circular 17, I am not going to discuss because Colonel Leach from Personnel will cover that shortly. It merely outlines The Surgeon General's policy with regard to assignments in this program. The last paragraph of this circular states that officers selected to attend professional courses at a civilian institution will render a report to The Surgeon General upon their completion of the course. This report should include the name of the institution, the course, the length, the date completed, and remarks as to the value of the course in their specific case. That is, too elementary or too advanced and remarks as to the value of the course in general. This will help us to evaluate these courses and determine as to whether or not we will send other officers to them.

Gentlemen, in these four (4) documents, I believe you will find everything you need with regard to the program. It has been in operation in our general hospitals since last fall and more recently in station hospitals. We have approximately 300 officers in the program at the present time. Approximately forty-five (45) of them have completed six (6) months training. We have sent 168 officers to civilian institutions for training for courses varying from one (1) to six (6) months. We now have eighty-one (81) officers in civilian institutions. Some thirty (30) officers have completed their training and will take their board examinations this fall. Many of the American specialty boards require a review of the basic sciences and we have contracted for such courses at three (3) of the Class A medical schools. We are operating a full-time course at the University of California for twenty (20) students. This is a four (4) months course. We are operating a similar, part-time school at George Washington University here in Washington and at the University of Colorado. I would like to repeat that this is purely a competitive program. The Army can't make specialists of these individuals. The Army can only furnish the facilities and means. The individual officer will have to make a specialists of himself. I would like to stress the importance of the local educational committee. These committees must function if the program is going to be a success. They must take an active interest in each individual officer and see that the quarterly reports are made properly. They should review the diaries of each individual officer, insure that the semi-monthly seminars are conducted and the clinical pathological conferences and staff rounds are made each week. Each officer in training should be stimulated in his collateral reading by assigning him subjects on which to report at the seminars.

The large station hospitals in which we are attempting to establish approved residencies in internal medicine and general surgery as follows: First Army Area — Fort Jay and the Air Force hospital at Mitchell Field; Second Army Area -- Fort Meade, Camp Lee

and Fort Knox; Third Army Area — Fort Bragg, Fort Jackson, Fort Benning and the Army Air Force Hospital at Kessler Field; Fourth Army Area — none; Fifth Army Area — Fort Sheridan; Sixth Army Area — none.

DISCUSSION:

GENERAL BAYLIS: Fort Jackson is down to about 200 beds and I do not think that this hospital could support a residency in medicine or surgery.

COLONEL DUKE: The patient load and clinical material available at this hospital will have to be reviewed and if it is felt that a residency in general medicine in surgery cannot be supported, we will withdraw this one from the list.

COLONEL WILLIAMS: I would like to have Camp Polk looked into as a possibility for this training.

COLONEL DUKE: We will survey the hospital at Camp Polk with reference to professional training.

COLONEL ROGERS: Has Fort Sheridan been approved yet? I question very much as to whether this installation will have the necessary type of work for residency training.

COLONEL DUKE: Fort Sheridan was surveyed some time ago and has not as yet received the approval. It is possible that the patient load has dropped here to the extent that at this time residency training would not be feasible there. We will check this one also.

GENERAL BAYLIS: The difficulty lies in keeping proper specialty personnel to do this training. What about the policy as to rotation in order to give everyone some professional training?

COLONEL DUKE: We realize this and that is the specific reason for setting up the consultants program. These consultants must be board members and they will supervise the training in these hospitals.

COLONEL KINTZ: As to the matter of rotation there is a paper in process right now that our officers will rotate every three (3) years from job to job, and from one major command to the other. There have been objections to this policy in certain headquarters and the present status is now that a certain percentage of company grade officers will be rotated rather than field grade officers. We plan to carry individual records in order to follow the professional career of every officer so that this rotation may be carried out.

2. The Postwar ROTC. -

Colonel Duke made the following statements in regard to the Postwar ROTC:

Prior to 1933 we had medical ROTC established in twenty-three (23) medical schools. It was discontinued in 1933 because of the lack of appropriations. It was established again in 1937 and in 1942 it was replaced by the ASTP, Army Specialized Training Program. The ASTP has now been discontinued and we are getting back to the ROTC program again. We have recently received from the War Department an approved policy concerning postwar ROTC and based on this policy we have formulated a medical plan. This plan has been submitted to G-3 for their approval. For the present time there will be no dental or veterinary ROTC as this was eliminated from the 1947 appropriation. We will make a fight to reestablish these in 1948. Statistical study shows that to fill the requirement for our organized reserves we should have a medical ROTC unit in every approved medical school. We will not be able to accomplish that this year but we do hope to re-establish the ROTC program in the twenty-three (23) schools which we had prior to the war. The plan as submitted to G-3 for approval is as follows: There will be a regular four (4) year course as it was previously: two (2) years of basic instruction and two (2) years of advanced instruction. If the individual student has been in the Army during the war for two (2) years, he will be given credit for the basic ROTC course, that is the first two (2) years and will be enrolled in the advanced course. If he has been in the Army from six (6) months to one (1) year, he will be given only one (1) year's credit and will be enrolled in the second year of the basic course. If he has had less than six (6) month's service no credit will be given. A summer camp will be required which may be attended during any summer of the four (4) years of medical school. This is an eight (8) weeks camp instead of six (6) as it was before the war. It is planned to bring all medical ROTC units to Brooke Army Medical Center at Fort Sam Houston for this eight (8) weeks course. Now, concerning the emoluments - at the present time legislation prescribes that there will be no pay for the basic course, and for the advanced course the student will be paid $21.00 a month. There is before Congress now a bill which provides for the payment of $21.00 per month for the basic course and $58.00 dollars a month for the advanced course. It is the opinion of the War Department that Congress will pass this bill.

We do not have at the present time sufficient Regular Army Medical Corps officers to assign them to the duty of PMS&T's. We are making an attempt to recall to active duty officers who have been in the service for two (2) or three (3) years and who are now on the staff of the medical school and assign them as PMS&T's or perhaps an

individual who is in practice in the vicinity of the school and can devote sufficient time to carry out this instruction. We will recall these individuals to active duty, send them to Brooke Army Medical Center for one month's PMS&T orientation course and let them be our instructors for this year. A letter has gone out from General Kirk to each of the deans of these twenty-three (23) schools informing them of this plan and asking that they nominate three (3) officers whom they feel would be qualified for this duty and acceptable to the schools and the Army.

Circular 138, on the reorganization of the Army, has delegated the operation of ROTC to Ground Forces and the army areas so that when this plan is approved by the War Department it will go to the army areas for placing into operation.

DISCUSSION:

COLONEL BLESSE: That paper is now in the Ground Forces and it gives but one (1) hour of instruction per week. The first thing that G-3 takes a crack at is the cost. Based on one (1) hour of instruction per week, this is a very high cost for what we are going to get out of it. Second, the question of instructors. I feel that we should detail Regular Army officers for this duty.

COLONEL DUKE: It is true that only one (1) hour of instruction in strictly military subjects will be given, but credit will be given for the other two (2) hours in subjects which are common to both military and civilian medicine. The individual will receive the most valuable training during his eight (8) weeks of camp during the summer at Brooke Army Medical Center. The value of ROTC is not so much in the one (1) hour of instruction per week as is the contact with the medical school in the procurement of officers for the Regular Army and also of the training received during the summer camp.

GENERAL KIRK: I feel that if the right man is selected for the job he can do just as much as any Regular Army officer can to further this cause.

COLONEL RICE: Has any thought been given to using National Guard officers as instructors on the ROTC program.

COLONEL DUKE: This could be done. We thought that it would be much better to have an officer who was already on the staff of the medical school. A detailed schedule is planned so that each instructor at each school will be giving the same thing at the same time.

GENERAL WALSON: I would suggest the use of training film strips. These have good proaganda value.

COLONEL DUKE: At the one (1) month's orientation course for PMS&T's at Brooke Army Medical Center, these officers will become very well acquainted with the training aids, film strips, and training films which will be available to them. The course has already been outlined in detail and instructors will be given instruction on each hour which they must teach.

Question 1: Is it contemplated that all Medical Department enlisted personnel be given basic military, basic technical, common specialists, and technician's training at Medical Department training centers prior to their assignment to other than mobile Medical Department units? What part of this training is contemplated for Medical Department enlisted personnel to be assigned mobile Medical Department units?

Answer : It is contemplated that all Medical Department enlisted personnel after being inducted or enlisted into the military service will receive a period of basic military, basic technical and our common specialty training prior to their assignments. Those trainees who possess the required prerequisites will receive further formal training in the enlisted technician schools in one of the following courses: Medical, Surgical, Pharmacy, Laboratory, X-ray, Dental and Equipment Maintenance. At the present time authority exists to give basic technical and common specialty training for those trainees being assigned to reserve units.

Question 2: Will all Regular Army Medical and Dental Officers now in administrative positions be eventually given an opportunity for refresher training?

Answer: : All Regular Army Medical and Dental officers now in administrative positions will eventually be given an opportunity for refresher training - insofar as the military situation permits.

Question 3: How will medical training of general reserve and civilian components be coordinated? When will the Medical Department training program for Regular Army and civilian components be made available and how will same be coordinated on a War Department and Army level?

Answer : There will be no coordination between general reserve and civilian organized reserve units since the general reserve is the strategic striking force in the Regular

Army set aside for any future eventualities. The Medical Department training program for Regular Army now exists under provisions of MTP's 8-1, 8-2, 8-3. Training programs for the civilian components, National Guard and Organized Reserve, are being drawn up by the Army Ground Forces and will be coordinated on that level.

3. Brooke Army Medical Center. -

Brigadier General John M. Willis, Commandant of Brooke Army Medical Center, discussed the organization and functions of the Brooke Army Medical Center, Fort Sam Houston, Texas. A chart showing the organization of Brooke Army Medical Center is attached herewith as inclosure No. 5. A chart showing the flow of trainees through the center is attached hereto as inclosure No. 6.

J. PREVENTIVE MEDICINE.....Colonel Karl R. Lundeberg

Colonel Karl R. Lundeberg, Chief, Preventive Medicine Division, Office of The Surgeon General, led the following discussion on Preventive Medicine matters:

COLONEL LUNDEGERG: A proposal has been made to publish in the Bulletin an elaboration of the opinion of The Surgeon General of the preventive medicine divisions in army areas and other organizations; therefore, it will not be necessary to go into that today. A word about the medical inspector or the head of the preventive medicine divisions in the army area: he is the key man in the whole preventive medicine program in army areas. I regret that of fourteen (14) Regular Army students at public health schools last year, only three (3) could be made available for assignment in army areas because of heavy demands from overseas and also because several of the men were primarily laboratory men. The training program contemplates training six (6) to eight (8) men during the coming year. Some talent from overseas may be available later. Three (3) graduates from these courses were made available, one (1) to the Third, one (1) to the Sixth and one (1) to the Fourth Army Area. The special questions submitted by the Army surgeons will be considered at this time.

Question 1: Is there any objection to discontinuance of the "Semi-Annual Report of Geographical Locations in which Venereal Diseases were acquired"?

COLONEL LUNDEBERG: This seems to be not too important, as day before yesterday Congress eliminated the Federal Security Agency for whom we were collecting this information.

GENERAL KIRK: Will it be necessary to have a Public Health Service officer on your staff?

COLONEL RICE: Mine left last month.

COLONEL WILLIAMS: We never had one.

COLONEL ROGERS: Very valuable man--doesn't come under ceiling.

GENERAL KIRK: Parran has trouble too. He is trying to get doctors from us to meet his requirements.

COLONEL LUNDEBERG: How many army surgeons would like Public Health Service liaison officers? Second, Third, Fourth, Fifth, Sixth -- all except First.

GENERAL WALSON: I want one too, if everyone else has one. However, it seems to me there will be a lot of ramifications designating USPHS officers in an Army surgeon's office. I think the Army should feel great pride about future venereal disease control. Some years

ago Dr. Parran got into the USPHS picture. I can say there will be a great deal of adverse comment made on what the USPHS is doing to take care of Army jobs in Preventive Medicine Division. I feel it is something which should be weighed very carefully before we start in with USPHS officers. I had one during the war. They did not do much for us when you come right down to it.

GENERAL BAYLIS: I disagree. I had just the opposite results. Both in the early part of the game and later in army areas, when it comes to venereal disease control in extra-cantonment areas. I still think there is a lot to be done for us. For example, near Fort Jackson, there is a great lack of united effort with the local civilian police and health agencies, state, county and city health agencies to do anything about that rule and unless somebody, that is the PHS man, is in the position to prod him along, it will not be done, and it is not very appropriate for us to do it. They resent our doing it, since active fighting is over. A PHS man can do more with civilian agencies. If I remember correctly, the PHS has a whip hand over them in that they gave them certain money to spend in Rapid Treatment Centers, etc., which all tied in. Our venereal disease rate today is certainly nothing to be proud of and I think we can accomplish more by concentrating on that phase and eliminating the source of the disease rather than punitive punishment for the individual after he contracts it. Then the environmental sanitation, control of restaurant sanitation, and malaria is a problem and will be a problem. Malaria is preventable and our medical inspectors cannot very well go into the city and tell them what they ought to do to prevent our men from getting malaria there. The PHS officer can. They are liaison in sanitation as it applies to eating. They also have a part in placing civilian communities out of bounds for soldiers, particularly regarding eating. The Army ought to have the support of the PHS and contact with the civilian health agencies. Their system is much better than ours and always will be. I am for it.

GENERAL WALSON: The USPHS officer in New York City had the finest group in the District Office and gave 100% support. Environmental sanitation is a big menace. I would notify him and he got in touch with the PHS officer who looked into it and corrected it. I did not have to have him in my office. As I understand venereal disease control in the Army, I feel it is not the job of the PHS but the job is ours. I have never been in favor of treating venereal disease cases as outpatients. I believe we ought to put gonorrhea patients in hospitals until we consider them free from disease. I made a study of it and had an opportunity to see cases treated in both ways. First, those with acute gonorrhea whom we insisted be hospitalized and those who were treated the other way, treated on account of complications. I don't see why we need a PHS officer in the office when the services of the District Office are available.

COLONEL ROGERS: My problem extends from the Great Lakes to the Rocky Mountains, and I consider a PHS man very valuable to me in that vast area, if he is under my control. They can go where the hot spots are.

COLONEL WHAYNE: The Social Protection Division of the Federal Security Agency has been dissolved by an Act of Congress. It collected data on prostitution on which the May Act could be invoked. But, however, the PHS can make the necessary studies, particularly in civilian areas, as General Willis pointed out, for they are in a position to get this information to tie in with various control activities, particularly as it pertains to extra-cantonment areas.

COLONEL ROGERS: We had a recent incident in Battle Creek. Very much worried about Anopheles mosquitoes present and the presence of malaria patients worried them. It was ideal for a PHS man to go up and make a survey as he had done before, sending comments back with assurance there was no danger. Everything under control but was acute for several days.

COLONEL LUNDEBERG: The service of these liaison officers with PHS was a wartime measure. It indicated concern of parents for care of millions of soldiers congregated in military areas and certainly served a useful function during the war. No matter how much you want to have these people it is doubtful if General Parran will let us use their personnel much longer - they are as pinched for personnel as we are.

COLONEL BLESSE: What is the possibility of getting an increase in number of preventive medicine men? That is one specialty a medical officer can always use - Army man in a key position - such training would be a very good background for him. Why not take that into consideration and increase the number even at expense of some other category. Get some out into the field.

COLONEL LUNDEBERG: The only way to do that would be to dip into the younger age group, that is, ASTP. It is becoming almost impossible to take men out of circulation - men capable of holding important administrative and professional assignments. It is a pretty serious thing for the Personnel Service. Every time we ask that somebody be taken out for training, it reduces the number available for regular duty assignments.

COLONEL BLESSE: They are doing it for other specialists.

GENERAL KIRK: There were twenty (20) men who went to school last year. There are six (6) areas and it seems to me these are your important jobs in the zone of interior.

COLONEL RICE: I have six states and no medical inspector at all.

COLONEL LUNDEBERG: We will provide these people as soon as we can get them. You can rest assured we are interested in getting them assigned to you.

COLONEL RICE: They gave them pretty good training at Carlisle in mess sanitation.

COLONEL BLESSE: What about running separate courses in order to step up the number that are coming out? That is the one thing we are continually being asked about. There are more vacancies in preventive medicine than any other place. Don't see how you can catch up. Even at ten (10) per year you couldn't catch up for years.

COLONEL LUNDEBERG: General Willis, your course in preventive medicine. Will that teach a certain amount of preventive medicine to all medical officers or will it be a specialized training for selected officers?

GENERAL WILLIS: All officers come through the same course. We can take just as many courses as are desired — but one qualification, you can't teach unless you have teachers. You must have additional classrooms, additional equipment and additional instructors. Some of them are now teaching four (4) to six (6) hours a day.

COLONEL BLESSE: I'd like to see that school of neuropsychiatry replaced by a school for preventive medicine.

GENERAL KIRK: I don't know why we cannot set up a course at Walter Reed, Army Medical Center, while waiting to start that class in malariology. Why can't a course like that be given out there, Holt?

COLONEL HOLT: No men to run it.

GENERAL KIRK: You have enough people out there to teach half a dozen men.

COLONEL HOLT: All right, we'll see what we can do about it.

GENERAL WILLIS: You can teach twenty (20) as well as six (6).

COLONEL LUNDEBERG: We'll follow that up.

Question 2: What is the policy on the establishment of prophylactic stations in cities frequented by military personnel but without any nearby military installation; for example, Pittsburgh, Pa?

COLONEL LUNDEBERG: I think we can summarize our point of view this way. We don't insist on pro stations at any place. We feel that greater reliance should be placed on individual pro kits. With the decrease in Army it is not economical to put up pro stations in every place soldiers may wander into. Major Altshuler, Venereal Disease Control Officer, is here for any questions on that.

GENERAL BAYLIS: At first we all used and encouraged the establishment of these stations and scattered them all over the army areas. Then when personnel began to get scarce, the minute we closed them we heard a howl all down the line. We certainly had reached the point in preventive medicine when it gets down to dollars and cents. I think the returns we get are not commensurate with the expenses. We have recommended that any number be eliminated, falling back on the individual pro kit.

COLONEL BLESSE: That was brought out concerning the high rates in Europe. The War Department wanted comments on their thought of putting back the court-martial system. We talked it over here between The Surgeon General and ourselves and put in a recommendation that they not go back to court-martial system except where they had hidden the fact of venereal disease and that we would open up on men who were repeaters in the hope of getting rid of them. As far as pro stations are concerned, they got to be more of a station of record. Of course, the old system all depended on that little record made by somebody who so often got caught making a mistake. The soldier probably got six (6) months. Wasn't right at all. They went along with that and that is what has been recommended. They only try those who have hidden the fact that they had venereal disease, putting emphasis on the individual pack and trying to get the repeaters out as being unqualified for service.

GENERAL BAYLIS: Strange thing in our army area was that certain questions were sent down by The Surgeon General, through military channels, as to what our ideas were about going back to punitive measures. Our office said no. But when the Commanding General forwarded it he sent our memo and it said yes. He disagreed with the recommendations of his surgeon.

GENERAL WALSON: We had the same thing.

MAJOR ALTSHULER: The commanding general stated that he was in favor of punitive measures and that his surgeon did not concur in his ideas, and he was forwarding the comments of his surgeon. In regard to punitive measures, as you all know, this office conducted a survey requesting the comments of the service command surgeons and theater surgeons. The concensus of opinion was in favor of some type of punitive measure that could be effective without driving VD underground or encouraging concealment. Our feeling on this level is that VD

should be considered as misconduct and LOD determination be changed from LOD Yes to LOD No. We are open to suggestions as to the type of punishment that would effectively control VD without encouraging infected individuals to seek treatment by quacks and druggists, thus leading to severe complications. Another thing to be considered is that the control of VD is a command function and yet the commanding officer has nothing to enforce this function of command.

COLONEL LUNDEBERG: We might say the War Department has been on the spot all spring on this problem -- it goes back to the question of condoning prostitution. All of those who served in Europe and North Africa know of the bitter letters written from responsible commanders over there on handling VD. The CO no longer had authority over his troops, no chance to punish them, and there were some very excellent, thoughtful letters written deploring such a state of affairs. The purpose of our survey was to collect the best ideas on the subject. How far should we go back on the return to punishing for VD? What favorable methods of control can be put in the hands of commanders? We must admit we have no brilliant ideas on the matter.

Question 3: Field Manual 21-10 at present emphasizes the use of fly traps around mess halls and similar installations as a fly control measure. Sanitary engineers state that use of DDT is superior in effectiveness. Is there any change contemplated in the Field Manual?

COLONEL LUNDEBERG: Fly traps are not compulsory. DDT control is better. FM's to be changed.

GENERAL WALSON: Are you going to do away with fly traps?

COLONEL LUNDEBERG: I don't think your medical inspectors will fuss if you are using DDT on screens and don't have any flies.

GENERAL WALSON: We are not using fly traps in the First Army Area. We have fly papers in the mess halls and we take them down once a week and count the number of flies caught on the paper. We have been little bothered so they say.

GENERAL BAYLIS: You mean you put it up there and leave it up one day?

GENERAL WALSON: No. We leave it up one week and then count the flies -- just a gauge of how many flies are held.

Question 4: Installations with Training Centers, such as Aberdeen, continued to be overcrowded despite the request for a decrease in personnel consistent with the ability of the post to house and feed them in accordance with Field Manual 21-10 and ASF directives. Is anything definite being done in the War Department to correct this situation so that it will not recur this winter?

COLONEL LUNDEBERG: We are doing all in our power to keep the CO's from overcrowding. WD Circular 262, 30 August 1945, stated that troops were to be allowed sixty (60) sq. ft. per man. You all know we were overcrowded during the war in spite of all The Surgeon General could do. Just at the end of the war we got permission to have sixty (60) sq. ft. per man. Last spring during an epidemic of "strep" the Deputy Chief of Staff for service commands prescribed a minimum of sixty (60) sq. ft. per man in barracks. The present and future policy of this office will be that sixty (60) sq. ft. must be maintained in order to safeguard the health of the troops. WD Memo 100-46, 2 April 1946, which looks into postwar building, prescribes a minimum of sixty (60) sq. ft. per man in barracks. It prescribes seventy-two (72) sq. ft. for grade six (6) and seven (7); ninety (90) sq. ft. for grade four (4) and five (5); 180 sq. ft. for noncoms in grade one (1), two (2) and three (3).

COLONEL RICE: Aberdeen had quite an epidemic of scarlet fever last spring which caused overcrowding of hospitals all through the area. The Surgeon General got interested in it and went down to see what was being done. I went down there myself and spent two (2) or three (3) days. I happen to know the CO of the training center. They had 18,000 to 22,000 people and only room for 12,000. General Eddy signed a letter asking that the number of personnel in that training center not exceed 12,000 but nothing has been done. So many people go in there and so few come out that it is conducive to high sick rates, particularly in winter months.

GENERAL KIRK: I took that up personally with General Lutes, who sent a directive to check troop space allotment there and ordered that no more be shipped. There is one more thing of importance which hasn't been brought up besides space and troops. That is regarding mess halls and mess gear, where the soldier often gets his infection. Somebody has to do something about it. That spray apparatus that was designed by the Engineers last year is no good. There should be proper modern dishwashing machines in every place a soldier eats. Efficient dishwashing machines should be installed in every kitchen in this Army.

COLONEL RICE: At Aberdeen they are using them now.

GENERAL KIRK: There is no reason why they can't get those dishwashing machines in every kitchen for the cleaning of mess gear. There is a way, if you buy these dishwashing machines, and no reason why they can't be installed.

COLONEL BLESSE: Money.

GENERAL KIRK: Let them get the money.

GENERAL WALSON: There is a surplus of these modern machines in hospitals being closed. Many posts depended on old style dish-washing machines.

GENERAL KIRK: And I think it is your job to condemn everyone in question. I talked with Lutes about it and he is 100% in agreement.

LT. COLONEL REGAN: (Assistant, Preventive Medicine Division, SGO.) The Corps of Engineers is in the process of redesigning dishwashing machines.

GENERAL KIRK: Buy good dishwashing machines that are on the market.

COLONEL REGAN: The Bureau of Standards machines will be quite satisfactory. There is not any striking difference in sterilization chambers between them and those on civilian market.

GENERAL KIRK: But it does require a lot of intelligence to run one and there is not much intelligence in these kitchens. It took up to three years to find out the thing that would do the job. I think we need more modern machines in dishwashing. Those older machines are made out of metal and have a little piece of canvas tacked on the side. Same thing in our general hospitals--no good. Get something already on the market. Let's get them in there. I went up to that CWS outfit in Maryland (Detrick) the other day and they had a beautiful machine that cost $750. We had two in my hospital. We checked and everything comes out sterile. Up at Detrick they were washing lab petri dishes instead of mess gears to keep the soldiers from getting sick.

Question 5: Will oiling of barracks floors and blankets be a general practice this winter?

COLONEL LUNDEBERG: It is considered to be still in an experimental stage. There are a lot of difficulties that need clearing up. We would like to extend the experiment during the coming winter.

Question 6: Do Army headquarters now have any responsibility for environmental or unit sanitation at Class III installations?

COLONEL LUNDEBERG: I believe this has been discussed.

GENERAL DENIT: I consider it finished business.

GENERAL KIRK: I talked to Grow and it was acceptable to him. He would like to have it like it was, the same as consultants and sanitary engineers and preventive medicine men, if any. It may be he wants to think it over.

COLONEL LUNDEBERG: Well, there is a lot of difference in having a consultant and having a public health man go in there and actually direct sanitation. Environmental sanitation is a command job, as we all know. In the theater we got along beautifully with the Air Corps by sending in well-trained engineers and consultants from SOS. But the idea of actually going in and directing changes like in some installations, that is different.

GENERAL BAYLIS: I asked that question and I had in mind that this is a fact-finding thing. You find that when you put it up to them. After all, it's similar to a consultant's advice. We get the man there when it is necessary to have one. We can give them the facts as he sees them and, after all, it is an administrative matter whether he does anything or not.

COLONEL ROGERS: May I suggest that it be taken up with the Air Forces and have them publish something to the effect that we can go in there.

GENERAL BAYLIS: Modification or amendment of War Department Circular 138.

GENERAL WALSON: The way it was worded in the last ASF Manual is all right. Consultant gives technical advice; goes through channels. If he doesn't correct it, it goes up to the CO.

GENERAL BAYLIS: If they want it in some installations, it's not exactly a rebuff. But they were lukewarm as to whether they wanted us to do it.

COLONEL LUNDEBERG: The answer as you stated it is to send an advisor in there then.

GENERAL BAYLIS: Well, do we have the responsibility for making the inspection and then reporting it to them?

GENERAL DENIT: The answer to that question is, no! The next question is do we want the responsibility, and the answer is, yes!, if the Air Surgeon would like to have that service.

Question 7: Is it contemplated that army area laboratories continue to serve Class III installations the same as Class I and II?

GENERAL DENIT: We have asked that these labs be made Class II installations. Unfortunately, WDGS has not quite sensed the command channels because that was sent to AGF for comment. AGF put on an adverse recommendation. So far as I can see, it was not an AGF decision. However, it is a decision of the army commanders because they are area commanders and they report direct to War Department on certain matters. Would like to get you people to help us out when that comes down for decision. Determine whether or not they will agree these laboratories should come under the control of The Surgeon

General because Air Forces have to utilize these labs. There should be a laboratory system for these units, a branch or extension of Army Research Institute. Have had promise that the LDGS decision would not be made until replies come back from army commanders. You can help us out on these things. You know The Surgeon General is very anxious to have these laboratories as Class II installations.

GENERAL BLISS: That will be a change in Circular 138. Want Class II lab, now under control of army commanders. Should not go to Ground Forces. Three (3) are now Class II.

GENERAL KIRK: Which are the three (3)?

LT. COLONEL CAVANAUGH: (Chief, Laboratores Branch, Preventive Medicine Division, SGO) One (1) at Brooke and one (1) at Madigan. Army Medical Center is also Class II.

GENERAL BAYLIS: Here is a difficulty. Laboratories have a responsibility in preventive medicine. Want to send group to investigate - where to go to get the orders? They call in from some station with three or four new cases and want somebody on the job right away. We should be able to issue orders for temporary duty and send them down there.

GENERAL KIRK: You as our technical representative there can issue orders.

GENERAL DENIT: That is reason we want you to supervise all Class II installations.

GENERAL BAYLIS: Have occasional difficulties. Do everything we can to overcome them. What direct instruction do you want to give them?

COLONEL LUNDEBERG: The SGO wants to control personnel.

COLONEL ROGERS: You do that anyway.

GENERAL DENIT: We want to establish a system of research and scientific development and have the whole thing head up here in a central agency. We don't want army area labs to be looked upon as routine proposition. They should serve as extensions of Army Institute of Pathology. One objection: occasionally there are times where you have to issue orders to get a man out quickly.

GENERAL KIRK: Doesn't General Willis have authority to issue orders to send a man anywhere he wants? Doesn't the CO at the St. Louis Medical Depot have authority to send a man in his depot anywhere?

GENERAL DENIT: Give CO of that installation authority to issue orders.

GENERAL KIRK: What about if Air Corps in Class III wants them?

GENERAL BAYLIS: Would you have any more right to go there?

GENERAL DENIT: Yes! If you are in charge of everything.

GENERAL BAYLIS: You can go in there and inspect problems. Find out what is the matter.

GENERAL DENIT: That would improve the over-all lab service.

GENERAL HAGIN: Two reasons for wanting to transfer my lab over to Letterman now out of Monterey. Takes up to three days to get specimens in my office. Will never be able to get them going if they are part of the Sixth Army. Also, conserve personnel. Letterman will need their services as much as anybody else. I see no reason why we can't call on them just as we do Letterman for consultation. Can get air transportation anywhere. CO promised to send any specimens I wanted. I believe it would suit us better if we can turn them over as Class II installations.

GENERAL BAYLIS: It suits us if we can get direct promise of 100% service.

GENERAL DENIT: That is the agreement if you sell this to the army commander; We have reason for asking army to make labs Class II installations. They service Air Forces as well as Ground Forces. It makes for more efficient operation, and better scientific personnel can be detailed. Only three (3) remaining and others are under way and working effectively. We want dental lab same way. There are only four (4) of them trying to serve six (6) areas. War Department has no serious objections but the CG's of the armies have not been contacted.

COLONEL BLESSE: Same conception of Class II installations as you get here. You will run into difficulties with the army commanders. Means they have nothing to do with that except to furnish certain personnel and have few things outlined in circular. In doing it that way you will not be able to have the same use of it. Too many Class II installations absolutely swamped in the army area and can't handle it that way. Running into blank wall.

COLONEL ROGERS: Not true in the Fifth Army.

GENERAL DENIT: I think you can see the advantage of setting up scientific branch headquarters here in Washington. All of it comes in here for examination. Furtherance of program of research.

GENERAL BAYLIS: One thing rubs the wrong way. Have had a great deal of responsibility of getting civilian personnel.

GENERAL KIRK: That is not our fault. The Surgeon General will be glad to handle that for every Class II installation. Technical service set up under this new organization. Meets over-all need in prevention of disease as well as treatment of sick and the making of teeth.

GENERAL BAYLIS: Results in divided responsibility - that is the part that galls them.

GENERAL KIRK: They have no responsibility except to see that men are assigned to that office and to replace them. They have major court martial jurisdiction.

GENERAL DENIT: Divided responsibility? According to Circular 138, army commanders have divided responsibility. They are not required to transmit thru AGF anything that pertains to area control. The new organization of the Army outlines the divided responsibility of army commanders.

GENERAL KIRK: When something goes wrong with a patient sick in the hospital, who answers the letters - The Surgeon General. He gets the responsibility.

GENERAL BAYLIS: Gives me more headaches - more complaints from Class II installations than they do from Class I. The Surgeon General has certain technical responsibility and should have free hand. I am presenting point of view of other people who have to do that work. Strange thing, Class I installations can go right along smoothly. More difficult to run Class II.

GENERAL KIRK: If you can change regulations right now, it will suit us. Quartermaster and Engineer complements are put in by army commander instead of here in Washington. Recommendation coming from Sixth Army that Class II be turned over to technical people. Let them run the thing, lock, stock and barrel.

GENERAL HAGIN: General hospitals were run by The Surgeon General before the war. I think he ought to get them back.

Question 8: We are now receiving monthly sanitary reports from general hospitals and Army Medical Center. Under Circular No. 138 we are not responsible for preventive medicine and sanitation at general hospitals and Army Medical Center. Recommend that monthly sanitary reports continue to be forwarded to this headquarters from general hospitals and that this headquarters then take necessary action to correct sanitary defects listed in the report prior to indorsing the report to your office.

COLONEL LUNDEBERG: I believe the first statement is correct. All sanitation and preventive medicine should be under the Commanding General of the army.

COLONEL WILLIAMS: We would like to see all sanitary reports come thru army commanders' office.

COLONEL ROGERS: Suppose I sent Captain So-and-so over to inspect General Bastion's installation in regard to sanitation. In the first place, I don't think they need it, and, second, it would be embarrassing to me and General Bastion. It is an awkward situation. They are all senior officers running a good show.

GENERAL KIRK: Just send him when he asks for him. Look over sanitary reports once a month.

COLONEL ROGERS: It's impractical. Embarrassing to CO to send majors to look at your unit.

GENERAL KIRK: Not unless something goes wrong.

COLONEL RICE: The answer is this - when we send a man down to Camp Meade, he goes as representative of army commander and therefore he can speak for army commander. But if he goes up to Valley Forge, army commander will not permit him to inspect for him. Would have to go as representative of The Surgeon General. They are very fussy about chain of command.

GENERAL BAYLIS: As it is a purely sanitary matter at Class II installations, medical and dental services were excluded. Sanitation still goes on.

Question 9: What does The Surgeon General expect of the Army Surgeon at Class II medical installations, to include preventive medicine?

COLONEL LUNDEBERG: Most of these Class II medical installations do not need any particular preventive medicine supervision. However, we feel sanitary reports should go thru surgeon's office. Keep track of trends, etc.

GENERAL BLISS: I think The Surgeon General expressed in T X that army surgeon would be his technical representative at Class II installations. You are allowed to tell them you are his representative on anything you think is desirable or necessary. There is one more similar question. Responsibility at AGF and AAF stations for medical service, VD, insect and rodent control should be army instead of AGF or AAF.

GENERAL WALSON: That has all been covered and is going to be straightened out.

COLONEL LUNDEBERG: Before closing, would like to ask Colonel Regan to make statement about recent trends with respect to service of Corps of Engineers in environmental sanitation.

LT. COLONEL REGAN: I believe that everyone is aware that operation of sanitation, as it applies to water supply and insect and rodent control, is now being taken over by the Corps of Engineers, Repairs and Utilities Division. That has been true a number of years. Under that system the Chief of Engineers has two (2) entomologists employed in civilian capacity. They cover over-all picture through the various army areas. You find entomologists usually anywhere from P4 to P6 ratings. Same system is going to be extended overseas. We feel here that we are getting very good cooperation with Repairs and Utilities. They don't make any moves without consulting us. Have been informed that the same cooperation exists down at the army headquarters. Quartermaster Corps is responsible in supply. We get utmost cooperation in securing various insecticides and rodenticides. As far as movement of supplies - no complaints as yet. Perhaps some of you could give me some information on this. Not necessary to use entomologists in the surgeon's office. Very short of them. Only two (2) at present in Regular Army. Hope to have more. There is entomologist in your engineer's office supposed to cooperate with army surgeon. Would take care of entomology in headquarters. Sanitary engineering situation is not as good as it might be. We hope eventually to be able to assign one (1) in each HQ of surgeon's office. Unfavorable publicity recently released. Criticism seems rather widespread because of the fact that sanitary engineers consider they are high qualified professional group. Try to point out to likely candidates what the value of one (1) auxiliary coprs will be. We will continue publicity and try to get more applicants at future integration. Would appreciate it if down at headquarters and various posts, camps and stations encourage well-qualified sanitary engineers to consider application for Regular Army. There is a definite need for these men. We could have taken twenty-two (22), only have nine (9). It is to be assumed that on second integration will have more vacancies. It was proved during the war that the sanitary engineer is valuable aid to chief, preventive medicine, in carrying out medical program. Don't feel Corps of Engineers should approach problems from public health angle. They emphasize cost and economy of construction, etc.

COLONEL LUNDEBERG: Sanitary engineers are not qualified to be <u>medical</u> inspectors. They should be used as assistant medical inspectors under the chief, preventive medicine. Training qualifies them to take over problems of water supply, waste disposal, insect and rodent control. Physical examination and knowledge of bacteriology necessary to identify all disease and to control acute respiratory disease, etc.

COLONEL ROGERS: These men would not have training for that.

COLONEL LUNDEBERG: I have been on posts where they have sanitary engineers and entomologists looking at throats and doing VD inspections. Chief of preventive medicine must be a doctor with special public health experience and training.

GENERAL BAYLIS: Hope to get three (3) officers in preventive medicine section and also have a Sanitary Corps officer for sanitation.

COLONEL LUNDEBERG: Sanitary engineer is most important man next to chief of preventive medicine.

GENERAL BAYLIS: I would like to have a nutritionist.

GENERAL WALSON: I believe that at army level the surgeon's office should be equipped with specialists under a qualified preventive medicine officer and there should be a sanitary engineer for environmental sanitation, water and sanitary engineering. Nutrition officer has a lot of work to do on account of food conservation. Really Medical Department job. Important that you have, if possible, an entomologist. Reason is Engineers have an entomologist in their setup. We are on inspectional level and make recommendations. How can we criticise the entomologist if the Engineers have him? Medical Department checks up on work of Engineers who are doing it.

COLONEL LUNDEBERG: Danger of the thing getting out of control. Should have well-trained and experienced sanitary engineer to insure that the Corps of Engineers is doing its job according to health needs of the command.

GENERAL WALSON: How about chemical warfare? Never have taken a great part in the thing. No change in regulations.

COLONEL REGAN: Circular 168 mentions activities of the Chemical Warfare Service.

GENERAL WALSON: C W S supplies and supervises use of dangerous cyanides in fumigation.

GENERAL BAYLIS: There is the problem of industrial hygiene and medicine. We have called on industrial inspectors from Edgewood to come in and do this inspection for us and I doubt if we have enough of that type of work in our area to keep a full-time man.

COLONEL LUNDEBERG: Army Industrial Hygiene Laboratory at Edgewood will continue to send technical advisors upon demand. Major Duguid is heading that laboratory.

MAJOR DUGUID: Based on our recent records the War Department has approximately 200,000 civilian workers in Army industrial plants, exclusive of the Air Corps. The Army Industrial Hygiene Laboratory located at Edgewood Arsenal has conducted and will continue to conduct Army industrial hygiene as far as all Army-operated industrial installations are concerned, and special investigations when necessary to evaluate industrial health hazards and to make recommendations for their control. Industrial medicine is a specialty. In order to conduct a satisfactory industrial medical program at plant level it is necessary to have physicians who are qualified through experience and training in this field. With that in mind, we have recently been working on job descriptions for industrial physicians with the view of offering salaries that will attract qualified physicians. We are quite sure that a grade of P5 industrial physicians at plant level will be authorized. If the industrial medical problems at army headquarters level are sufficient to warrant the employment of specially trained industrial physicians to supervise the program in the area, it is expected that grade P6 will be authorized.

GENERAL BAYLIS: If we had some gas shells to be moved, I would have to have somebody in there who knows about handling. At Mobile and at Charleston you sent somebody in to give special supervision.

MAJOR DUGUID: Any time you have a special industrial medical problem for special investigation you may call on the laboratory. Technically trained men will come around at least once a year to survey each army industrial installation.

COLONEL LUNDEBERG: For the information of the nutrition officer, an expression of opinion as to how many surgeons will require nutritionists is desired. Scarce category. Got only two (2) in recent integrations.

GENERAL BAYLIS: I would like to have one and unless this manpower situation squeezes me so hard, could drop somebody.

GENERAL HAGIN: I have no place I could put him.

COLONEL WILLIAMS: I have one under orders.

COLONEL RICE: I have a fine one down there and no special problem, so assigned him to Quartermaster to work for me.

COLONEL ROGERS: Would be glad to have one if you think I should have one.

Question 10: Is consideration being given to requiring that all venereal disease be treated in hospitals rather

than permitting uncomplicated gonorrhea to be treated on out-patient status?

Answer : There is no clinical evidence at this time to prove that the treatment of acute uncomplicated gonorrhea on a duty status is other than satisfactory. This method has been recommended because of the high incidence of gonorrhea among troops. To hospitalize all cases would place a tremendous burden upon our hospitals that are now under-staffed and over-worked. It must be remembered that beds occupied for the treatment of gonorrhea cannot be made available for more serious conditions. The Office of The Surgeon General is deeply concerned with the failure of some hospitals to require the restriction to the post for a period of at least twenty-one (21) days of all infected individuals. It would ask that a system of checks be instituted to guarantee that these individuals are being restricted. Treatment of infected individuals on pass or furlough by general dispensaries should be discouraged. Those individuals living at home or in rooming houses act as public health menaces not only to themselves but to the civilian population as well. Infected individuals in this category should be referred to the nearest Army hospital for observation and treatment and at the completion of treatment returned to his station for the required restriction.

K. MEDICAL SUPPLY

Colonel Silas B. Hays, Chief of Supply, Office of The Surgeon General, made the following statements:

From time to time the question has arisen as to the establishment of a distribution depot in each army area. The decision has not been reached but we should have an answer in thirty (30) to sixty (60) days.

There is one thing you may not be entirely familiar with that has developed in the last six (6) or eight (8) months, and that is the creation of the Army-Navy Medical Procurement Agency in New York. This organization is under the joint administration of The Surgeons General of the Army and the Navy. It has a Specifications Branch, Catalog Branch, Purchase Branch, Inspection Branch, and Maintenance and Repair Branch, and is jointly charged by the Under Secretaries of War and Navy with responsibility in these particular fields.

It has been General Kirk's policy all along that the supply people not determine allowances, nor determine standards and quality of material. Allowances in this office are determined by the operations personnel; standards and choice of items are handled by the research and development personnel. The Medical Department Equipment Laboratory is being absorbed by the Army-Navy Medical Procurement Office and will be moved to Fort Totten, New York. Technical supervision will be by the development personnel here and research and development personnel of both the Army and Navy.

Beginning 1 July 1946, we established a new procedure for supply of non-standard supplies and equipment in the zone of interior. We set up a money credit for each station, and within that money credit allowance it is entirely up to the hospital commanders as to what they buy. The only editing done against these purchases is by the depots, and this editing is for the purpose of seeing whether or not the same item is on the supply table as a standard item and of determining whether or not a proper charge against Medical Department funds and not Engineer or Quartermaster. We don't know if the money credit allowances are going to be too high or too low. They will be watched for the first two (2) or three (3) quarters and they will be increased if necessary.

The supply of hospitals at posts, camps, and stations for the past several years has been under the provisions of TM 38-220. This publication is now being revised and while we don't know exactly what it will be, we have already taken the matter up informally with Service, Supply and Procurement, and apparently it will be this way: Army headquarters will edit requisitions and excess supplies for organizations at our posts, camps, and stations. In the case of Army

Air Forces, they will go to that component. The technical services are responsible for supply to the stations as in the past and the station supply levels will be approved through the depots as in the past. We have protested on two (2) occasions the low level (45 days) of supplies in hospitals. However, I doubt that it will be increased. I must say that we hear very few complaints that the level is too low.

The matter of determining the allowance of non-expendable equipment for hospitals has been under consideration for several months. During the war we got along with zone of interior equipment lists and expansion units. With reconversion to peacetime organizations, it will be necessary to have more uniformity than there was during the war. No two hospitals in the Army are exactly alike as to plant structure, mission, or bed capacity. We feel that rather than to try to make the hospital adhere to any set equipment list, it would be much better to establish central control by The Surgeon General over relatively few items, leaving all other items to the judgment of the hospital commander as to what he feels is necessary. We have put that into the revised draft of TM 38-220 and it will be published in that manner, your headquarters will not be bothered with any of that part.

Now General Kirk has felt, in fact all in the office feel, that it is essential that equipment standards of hospitals should be raised at least comparable with the best civilian or other governmental institutions. During the war, of necessity, we had to purchase a great deal of inferior equipment, such as beds, sterilizers, mattresses and things of that kind. Generally speaking, as far as technical equipment was concerned, we were able to maintain high standards and very little will have to be replaced. When you get into the equipment line, because of war times, we had to take much inferior equipment and some installations are better equipped than others.

General Kirk has chosen Colonel Robert M. Hardaway to head a team to inspect permanent general hospitals and the larger station hospitals to determine what each one needs. Prior to starting any such inspection, the team will have to establish standards for items of equipment such as operating tables, sterilizers, etc., so that the inspections can be made with some degree of rapidity. It will take about six (6) months to go around. We don't know how much money it will take to modernize them. We hope to have a few million dollars to put into this modernization this year. We hope too that Congress will continue to be liberal with us, so that we can carry out more modernization next year and bring Army hospitals to the highest standards.

DISCUSSION:

Question 1: Is the army responsible for medical supply at Class II medical installations?

Answer : The army commander is responsible for medical supply activities at Class II installations as stated in paragraph 6a (1) Appendix 2, page 33, War Department Circular 138, 1946, as amended by paragraph 10, War Department Circular 170, 1946. The specific responsibilities of the army commander with respect to supply activities are outlined in Section II, paragraph 3, TM 38-220, May 1945. This manual is shortly to be revised and it is expected that it will read as follows:

"Commanding General, army will:

* * *

(6) Inspect stations (other than National Guard and manufacturing plants) making certain that:

(a) Requisitioning procedures are being followed.
(b) Property issue slips are being filled promptly by station supply officers.
(c) Overissues are not being made.
(d) Stock record cards are up to date.
(e) Stock record cards reflect physical quantities of stock on hand.
(f) Inventories, as prescribed, are taken.
(g) All serviceable property is properly and promptly charged to stock record accounts.
(h) Turned-in property is classified expeditiously into serviceable, unserviceable, and unindentified in accordance with current instructions.
(i) Repairable property is repaired and returned to supply channels or is evacuated to higher echelon repair facilities without delay in accordance with current instructions.
(j) Station control levels are established and regularly reviewed and when necessary, revised.
(k) Revised station control levels are promptly recorded on appropriate stock record cards.

(l) Excess and surplus stocks are promptly processed in accordance with existing regulations.

(m) Instructions for the disposition of obsolete and nonstandard items are being adhered to.

(n) The chief of technical service concerned is advised if depots do not fill requisitions promptly.

(o) Model stocks, if any, are operated in accordance with existing regulation.

(p) Requisitions for newly activated units are being prepared in accordance with existing instructions."

The system of direct supply as set forth in TM 38-220 in the relationship between the distribution depot and installation commander is unchanged either as a result of the reorganization of the War Department or as a result of the designation of general hospitals as Class II installations under the command of The Surgeon General's Office. Requisitions and stock status reports will continue to be submitted directly to distribution depots. Salvage activities are under the army commander; surplus disposal activities are under The Surgeon General.

Question 2: What policy is to be pursued in the relationship between Army hospitals and dispensaries, and Army Air Forces hospitals and dispensaries, especially in regard to basing one or the other for routine medical supplies and equipment? This may usually be arranged by mutual agreements and cooperation, but it is awkward at times and makes for delays.

Answer : So long as The Surgeon General is charged with the overall responsibility for medical supply at Class III installations as well as Class I and II installations, it will be necessary, in the interest of economy of personnel, to base small using installations on a parent installation for medical supply even though one or the other installation may be under a different command. Where this arrangement cannot be worked out by mutual agreement by the local commands, coordination can be obtained through The Surgeon General's Office.

Question 3: At the Louisvelle Medical Depot we have an industrial dispensary which is a Class I function at a Class II installation. What is the policy of The Surgeon General in regard to coordination between the Army Surgeon and The Surgeon General of professional activities and of medical supply activities at this depot?

Answer: The army commander is responsible for the activities of the dispensary at the Louisville Medical Depot. The question is not clearly understood, however; if it is a question of medical supply responsibility for the dispensary, medical depots habitually draw supplies from their own stocks for their own use and likewise the dispensary can draw medical stocks for its own use from the Louisville Medical Depot if available. If necessary they can place requisition on the distribution depot.

L. MISCELLANEOUS DISCUSSION TOPICS - ANSWERS TO MISCELLANEOUS QUESTIONS SUBMITTED BY CONFEREES.

1. Physical Standards.

Question 1: This office screens "Reports of Physical Examination", WD AGO Form 63, of applicants for commission in the AUS. On the basis of recommendations made by this office, the Civilian Components Division of G-1 notifies the applicant whether or not he has passed the physical examination and whether or not waiver has been recommended or approved. In many instances, after an applicant has been notified that he is disqualified for appointment because of physical reasons, he receives a telegram from the Adjutant General notifying him that he has been appointed and ordering him to active duty. This results in undue hardship for the applicant concerned and creates ill-will for the Army. What can be done to coordinate the information given to each applicant by Civilian Components Division of the Second Army and the Adjutant General's Office so that conflicting information and orders will not result?

Answer : Section I, paragraphs 6a and 7b of War Department letter, file AG 201.6 ORC (9-6-40) R-A, Subject: "Physical Standards and Physical Examinations", dated 28 Dec 1940, sets forth War Department policy with reference to determination of physical qualifications of officers for extended active duty. As a result of interoffice War Department policy established on 25 July 1942, all reports of physical examination of officers adjudged to be physically disqualified for any type of military duty or physically qualified for limited service but unfit for overseas duty have been and are still being forwarded by the Adjutant General's Office to The Surgeon General's Office for review and final action. When such cases are received in the Office of The Surgeon General the report of physical examination is reviewed in conjunction with the officer's complete 201 file. As a result of this procedure, the Office of The Surgeon General has reversed the army's (service command's) decision in a certain number of cases. This reversal of decision is based upon review of past physical examinations, consultations and other pertinent data in the officer's 201 file. In many cases, a current consultation aids greatly in clarifying an officer's physical status in the light of information shown in the officer's 201 file. Reports of physical examinations of those officers adjudged to be physically qualified for general service or physically qualified for limited service but fit for overseas duty, are not forwarded to the Office

of The Surgeon General by the Office of The Adjutant General for any further review (in conformity with War Department interoffice policy).

This office is presently in the process of rescinding paragraphs 6a and 7b of the above-stated War Department letter. This contemplated rescission will make current office policy (as outlined above) a matter of record. That is, reports of physical examination of officers adjudged to be physically disqualified for any type of military duty or physically qualified for limited service but unfit for overseas duty, will be forwarded to the War Department (Officers' Reserve Branch, Assignment and Separation Section, Office of the Adjutant General) for review and final action. Subject officer will be notified in writing by the army area or department commander that the report of physical examination in his case has been forwarded to the War Department for review and final decision.

Question 3: This office is still reviewing the following matters which originate at Class III installations: (a) Certification for payment of civilian medical attendance vouchers; (b) LOD investigations; (c) Request for waivers; (d) Physical examinations not involving flying. Are we to continue to review these matters indefinitely?

Answer : The questions involve certain matters previously handled by the service commands for the Army Air Forces and now performed by the armies. From information obtained it would appear that the matters mentioned will be handled by the armies during the transition period, but that later, as a result of experience and study, it is expected appropriate changes will be made in procedure.

2. Physical Medicine.

Question 1: What are the general policies as to the scope and extent of physical medicine activities considered for small hospital units? What provisions will be made for allotment of equipment and authorizations and training of key personnel for this purpose?

Answer : It is not contemplated establishing Physical Medicine in hospitals under 1,000 beds. Small station hospitals will continue to function under ASF Manual M 8.

No courses presently available for any physical medicine personnel. Surplus of occupational therapists and physical

therapists now present in the Army in general. Training programs included at Brooke Army Medical Center for fiscal year 1946-47: (1) Physical Therapist EM SSN 072; (2) Occupational Therapist EM SSN 659 SK; (3) Physical Reconditioning EM SSN 283; (4) Physical Reconditioning Officers MOS 5521, which will begin October to December, 1946.

Occupational therapy equipment for hospitals of 250 beds or more is prescribed in ASF Catalog MED 10-23. Physical reconditioning equipment for hospitals of 250 beds or more is prescribed in ASF Catalog MED 10-25. Educational reconditioning equipment is not authorized for station hospitals, but obtainable from Special Services, Information and Education Division, USAFI, Armed Forces Radio Service, Army film libraries, etc.

The following authorizations of personnel have been made: one (1) occupational therapist per 250 beds; one (1) physical therapist per 200 beds; one (1) physical reconditioning officer per 500 beds.

3. Troop Units.

Question 1: The relationship of medical units not attached or assigned to subordinate commands to the army surgeon. Should this be "operational control" or direct command? While it is clear that as a staff officer, the army surgeon does not "command" units, it is believed that this subject would be proper for discussion, and clarification for all.

Answer : It is assumed that the question has reference to general reserve units. The medical units for which The Surgeon General has primary responsibility are stationed mainly at Class II installations. A few malaria control and survey units and one station hospital are stationed at other posts. Those units stationed at Class II installations are assigned to The Surgeon General for operational command. The Surgeon General has in turn further assigned the units to the Class II installations concerned and delegated responsibility for administration, supply, and training to the commanders of these installations. Those units stationed at other posts (not Class II installations) are assigned to the army commander of the army area in which stationed for operational command. The station of assignment is the determining factor for "operational command". If the station of assignment is an AGF post or camp, operational command of units stationed there is vested in the commanding general of the army concerned. If the station of assignment

is a Class II installation, operational command of units stationed there is vested in the chief of the technical or administrative service concerned. The relationship of the army surgeon to units stationed at Class II installations is the same as that existing between the army surgeon and the Class II installation proper. The relationship of the army surgeon to units stationed at posts other than Class II installations, is that of staff officer to the commanding general of the respective army. The question of "direct command" hinges entirely on whether such function has been delegated to the surgeon by the army commander concerned.

4. Medical Statistics.

Question 1: Certain operating reports, notably WD AGO Form 8-122 - "Statistical Health Report" - are required to be submitted directly both to The Surgeon General and the army surgeon. Each office then expends much time and energy in checking these reports for accuracy and sending out letters asking for corrections. In many instances the army surgeon receives a request from the Statistical Division, SGO, for clarification or correction of a report when the clarification or correction has already been made by this office or by the originating installation at the request of this office and forwarded to The Surgeon General. Can anything be done to reduce this duplication of work? Another example is the WD AGO Form 8-19 - "Report of Medical Department Personnel". Is there any reason why a separate report must be made out for veterinary personnel?

Answer : It is necessary that intensive "policing" of Statistical Health Reports and the resulting correspondence with units be undertaken by The Surgeon General immediately on receipt of reports, since data based on them must be reviewed, corrected, and ready for publication within a comparatively short period after the "as of" date of such reports. Adequate review of reports requires highly trained personnel under the immediate supervision of a central agency in order to insure uniform interpretation of applicable directives throughout the Army.

However, when information copies of letters initiated by army areas on the Statistical Health Report are received here, our outgoing correspondence is checked to eliminate duplication. Letters initiating in this office must, however, be forwarded to the units concerned immediately upon discovery of erroneous or questionable data, in order to insure receipt of corrected material before our publication deadlines are reached.

Question 2: What are the responsibilities of AGF at AAF stations to include: (1) Medical laboratory services, (2) Venereal disease control and reporting, (3) Insect and rodent control, (4) Veterinary inspection at point of origin. (Can AAF veterinary personnel be used for this purpose at points of origin and if so what is their responsibility to the army veterinarian?) (5) Medical statistical reporting?

Answer : Army surgeons are not responsible for medical statistical reporting from AAF stations. Information copies of the Statistical Health Report are forwarded to army area surgeons under the provisions of AR 40-1080; this device was designed to finish data on the incidence of communicable diseases at all stations in the geographic limits of a command.

Question 3: Request that careful consideration be given to again require that the Sick and Wounded Forms, WD AGO 8-23 and 8-24 be transmitted to The Surgeon General through medical channels.

Answer : The suggestion that the regulation (AR 40-1025) governing preparation of Reports of Sick and Wounded (WD AGO Forms 8-23 and 8-24) be modified so as to require transmission of these reports through medical channels, has been given careful consideration and has not been favorably considered for the following reasons: (1) A very rigid time schedule for the forwarding of the Reports of Sick and Wounded was established by Section III, War Department Circular 19, 1946, primarily in order to meet the needs of the Veterans Administration and the Adjutant General's Office for early receipt of medical report cards, but also in order to have current data available to The Surgeon General. This schedule requires that the report be forwarded within five (5) days of the end of the report period and allows only 20 days for complete processing in the Office of The Surgeon General. Additional handlings of these reports at intermediate echelons would further delay their final availability to the offices needing them and would make it virtually impossible for the established time schedules to be met as well as introducing an additional time lag in analysis at War Department level. (2) The tabulation and analysis of the Reports of Sick and Wounded at army levels would necessarily be based upon an incomplete set of data since only cases finally disposed of in the area or at the particular station would be available to the army surgeon. Thus certain of the more serious cases and some of the deaths and discharges would be excluded and would bias the results. (3) The editing and review of these reports at the army level could not be depended upon to insure the

necessary Army-wide uniformity and the complete review at the War Department level would continue to be necessary. Thus, the proposal would involve the army surgeon in work which would duplicate the efforts of the Office of The Surgeon General.

Question 4: Request that consideration be given to the amendment of AR 40-1080 and WD AGO Form 8-122 whereby additional weekly information be submitted to The Surgeon General and army surgeons to include the information now being provided the Surgeon, First Army as requested by letter this office to The Surgeon General, file SPGSM-M 704.5 (2nd SvC), Subject: "Weekly Statistical Health Report, WD AGO Form 8-122, dated 10 May 1946."

Answer : Letter referred to contained the suggestion that the number of Medical Department personnel (officers, enlisted, and civilians) along with a list of causes of deaths included in the report and the number of patients absent from hospital on leave or furlough, AWOL, temporary duty, etc., be added to the Statistical Health Report each week. While information of this type may prove very valuable at the army area headquarters level, it would not be sufficiently useful to The Surgeon General to justify its collection and processing each week from all installations. Par 6d of AR 40-1080 provides that supplemental information may be added to that required by the regulation at the direction of certain intermediate headquarters. This mechanism is available to army surgeons who require additional information on the health and hospitalization of their troops. However, it should be borne in mind that while the Statistical Health Report provides a convenient medium for the collection of many additional items of more or less desirable information, there exists a very definite danger of overloading it to the point that its preparation and transmission may be delayed and its value as a current report affected.

5. Nursing Consultants.

Question 1: There is a shortage of qualified nurse specialists in the Second Army. This applies especially to nurse anesthetists, MOS 3445. Most of the nurse anesthetists signed Category IV or V statements and have been relieved from active duty as they became eligible for separation. Can we expect that requisitions for these specialist will be filled in the near future?

Answer : An effort will be made to meet the current requirements for anesthetists through the immediate recall of nurses to active duty. It is also anticipated that in integrating nurses for the Regular Army, an opportunity will be given to select for commissions, nurses with special MOS's regardless of composite score.

Question 2: The hospitals in the area of the former Fifth Service Command were visited recently and a serious problem presented itself there. The nurses have been on a straight eight (8) hour schedule of duty, as follows: 7 a.m. to 3 p.m.; 3 p.m. to 11 p.m.; 11 p.m. to 7 a.m. This schedule requires an increase of approximately 25% in the number of nurses required to cover the nursing service. The hospitals in the Fifth Service Command previously had sufficient nurses to use the eight (8) hour day. The present authorization will reduce their number to a point where it will not be possible to maintain that schedule of hours. Most of the hospitals in the Third Service Command had not been a ble to adopt the eight (8) hour day because of the increase in authorization required for that schedule had never been approved by ASF. Sometime in the past, all service commands were requested by telephone from The Surgeon General's Office to use the eight (8) hour day wherever possible, but because there was no directive or written authority to cover this change, the Personnel Authorization Division of the Third Service Command did not approve an increase in authorization for the change of schedule. In order to obtain uniformity and prevent a decrease in morale incident to a change in hours of Fifth Service Command nurses, will a definite policy be forthcoming from the Office of The Surgeon General?

Answer : It is highly desirable to establish the nursing service on an eight (8) hour schedule in all army areas and general hospitals. However, it is impossible to do this under present restrictions imposed by the War Manpower Board on quotas. Until such time as new quotas are approved, duty hours for nurses should be uniform in all zone of interior installations with possible exceptions being made in extremely warm climates.

Question 3: Reference is made to War Department Circular 176, 1946, subject: "Recall to Active Duty". Shall nurses be advised to request active duty on WD AGO Form 160 at this time? Will courses in Anesthesiology be given to Category I nurses? If so, will the age be limited? Does successful completion

of courses given make the nurse eligible for membership in the American Association of Nurse Anesthetists?

Answer : Courses in anesthesiology may be given to Category I nurses in army installations. Age should not be limited. The course presently conducted in army hospitals does not meet the requirements for membership in the American Association of Nurse Anesthetists.

Question 4: What does The Surgeon General expect of the army surgeon at Class II medical installations in regard to nursing service functions.

Answer : The nursing service functions should parallel those of the army surgeon at Class II installations. An outline of the nursing service functions in army areas is as follows: (1) Assignment of nurses to army hospitals; (2) Recruitment of Reserve nurses; (3) In cooperation with Nursing Consultants Division, SGO, she will arrange training schedules for Reserve nurses; (4) Act as liaison officer with civilian nursing organization in respective army areas; (5) Submit to the Central Officers Assignment Branch, SGO, the names of volunteers for overseas duty; (6) Submit to Training Division, SGO, the names of nurses to be considered for the school at Brooke Army Medical Center and civilian institutions; (7) Contacting civilian hospitals with a view to meeting the senior classes to explain the functions of the Army Nurse Corps and advantages of nursing in army hospitals; (8) Inspection of nursing service of army hospitals, and also of Class II installations.

6. Veterinary Consultants.

Question 1: What are to be the responsibilities of army headquarters in connection with the veterinary inspections of meat, dairy, and food products for Class III installations? What are the responsibilities of AGF at AAF stations in regard to veterinary inspection at point of origin (Can AAF veterinary personnel be used for this purpose at points of origin and if so what is their responsibility to the army veterinarian)?

Answer : The army headquarters has no direct responsibility for making Class 3 inspections of products purchased by quartermasters at Class III, AAF, installations. However, should a quartermaster at a Class III installation desire to procure food products of animal origin from a vendor so located that point of origin could be more economically or expeditiously made by the army veterinary personnel rather

than by the veterinary officer assigned to the Class III installation concerned, it is believed appropriate for the Class III installation to request that veterinary personnel under the army's jurisdiction make the desired inspection. The army headquarters has no jurisdiction over any veterinary inspection conducted within a Class III installation and under current regulations reports of such inspections are forwarded to the War Department through AAF command channels and without reference to the army areas in which such installations are geographically located. Obviously, the Class 3, point of origin, inspection of most products of animal origin purchased by field headquarters, Office of the Quartermaster General, and by the several quartermaster market centers and destined for use at Class III installations will be made by veterinary personnel assigned to army areas. Currently, there is no authority for army veterinarians to demand that veterinary officers at AAF stations conduct Class 3 inspections desired by the army veterinarian, nor is there any thought that such provision will be made as it would be contrary to the basic principles of separate command. The Air Surgeon's Office has supplied The Surgeon General with a list of AAF stations at which Veterinary Corps officers are assigned and can be made available for Class 3 inspections within areas contiguous to their stations and has asked for a designation of those at which such service may be utilized. It is expected that a plan will be evolved whereby general procuring agencies and in some cases army veterinarians, may directly request that a veterinary officer at an AAF installation be directed to make a Class 3 inspection at a point in the vicinity of the station.

M. SUMMARY

General Denit asked the army surgeons just what specific changes they thought should be made in War Department Circular 138, 1946. General Baylis stated that the one thing not clear to him was just what the army surgeon's responsibilities and duties were with regard to Class II and III installations. General Willis stressed the point that by putting Class II installations under supervisory control of the army that it was putting one more block around hospital administration. He believed that if all Class II installations were under the control of The Surgeon General, their only connection with the army should be for court martial jurisdiction; that such things as personnel, supplies, engineers, inspections, etc., except court martial jurisdiction should come under the complete control of The Surgeon General. General Kirk said that if this were done it would have to be coordinated with every other service. General Willis believed that army commanders would be in accord.

General Denit asked if it was the opinion of the conferees that so much of WD Circular 138 as sets forth the functions of commanding generals of armies in Class II installations should be amended to transfer all of these functions to chiefs of services and that it be coordinated on a War Department level rather than at an army level.

General Walson recommended that army service units be abolished and technical service units be utilized. There would be, therefore, in those areas some professional representation.

General Kirk asked the surgeons to assist him technically with Class II installations. The army surgeons were asked to lend technical assistance to this office and advise this office by writing, telephone or wire, problems not going right in their installations. General Kirk stressed that this would be technical only -- not command. He stated that the consultants program should be utilized in general hospitals as well as in station hospitals. It was further stated that reports made by consultants should be submitted to army surgeons who will in turn transmit them to the Office of The Surgeon General.

The question of the hospitalization program in Class III installations was believed to be controversial. General Kirk stated that should the Army and Navy combine we might have, as in the past, too much duplication of medical service by Army and Navy, and if the Army Air Forces should become autonomous under the reorganization, they plan to have a complete medical service, thus causing further duplication.

General Kirk stated that he believed many of our present small hospitals would become dispensaries because of limited personnel. He pointed out that it would result in economy of personnel if the minor posts had dispensaries and the maximum medical service was provided by hospitals at major posts. No detriment in medical service would result if it was handled in this way since patients requiring definitive treatment could be sent to the major posts for hospitalization. Colonel Rice explained that this method had been used successfully in his area.

General Baylis asked if The Surgeon General concurred in closing nearby station hospitals in the interest of overall economy in personnel, and reducing such facilities to the status of dispensaries and letting a general hospital act as the station hospital in such instances. General Kirk stated that he is in accord with this procedure. General Denit added that the hospital program between the army surgeons and The Surgeon General be carefully coordinated to assure efficient use of station hospitals at small installations.

It was the general opinion of the conferees that Class III medical installations (hospitals) should come under the control of The Surgeon General but all agreed that the Army Air Forces should maintain flight surgeons in these installations to care for patients with diseases peculiar to the air force, and also, that this type of personnel could be utilized on air force maneuvers, etc. It was pointed out that at present air force medical personnel would rather do general hospital type of work instead of dispensary or station hospital work, and should be under common control of army surgeons all over the country. Colonel Rogers stated that he thought it would be worth fighting for.

General Denit asked the conferees if the present set-up as to the staff relationships set forth in War Department Circular 138 was going to be satisfactory. It was the general opinion that it was more satisfactory than under the former set-up.

General Denit told the conferees that we must get and maintain contact with civilian agencies in order to recruit for Regular Army Medical Corps and Reserve Corps. He stressed the importance of civilian schools and medical societies. Under training, the Office of The Surgeon General is trying to get ROTC in at least those schools that existed prior to World War II and would like the help of the army surgeons in the establishment of ROTC units in these schools. A list of those schools in the different army areas must be obtained along with suitable medical personnel to carry out this training at these different institutions.

The question as to whether the professors of military science and tactics are to abide by Army Regulations was brought up. General Denit said that they will be on active duty, and must conform to the regulations of the United States Army.

A G E N D A

THE SURGEON GENERAL'S CONFERENCE

18 - 19 JULY 1946

TIME AND PLACE	TOPIC FOR DISCUSSION - ACTIVITY	DISCUSSION CHAIRMAN
18 July 1946 - Room 2E-809, The Pentagon		
0800 - 0900	Register in Executive Office Room 2E-284, The Pentagon	
0900 - 0915	Welcoming Address	Maj. Gen. N. T. Kirk
0915 - 0930	Statement of Conference Aims	Brig. Gen. G. B. Denit
0930 - 1030	The Army Air Forces and Army Ground Forces under the War Department Reorganization Plan.	Brig. Gen. M. C. Grow Col. F. A. Blesse
1030 - 1200	Organization of Army Surgeon's Office and Relationship of Army Surgeons to Army Commanders in their dual capacity as Army Surgeons and Army Area Surgeons, Coordination between The Surgeon General and Army Surgeons of Professional Activities in Class II Medical Installations.	Brig. Gen. G. B. Denit, Col. F. A. Blesse, and Army Surgeons
1200 - 1300	Lunch - Officers' Dining Room Lounge Corridor 10, 3rd Floor, between A and C Rings	

18 July 1946 - Room 2 E-809 (Cont'd)

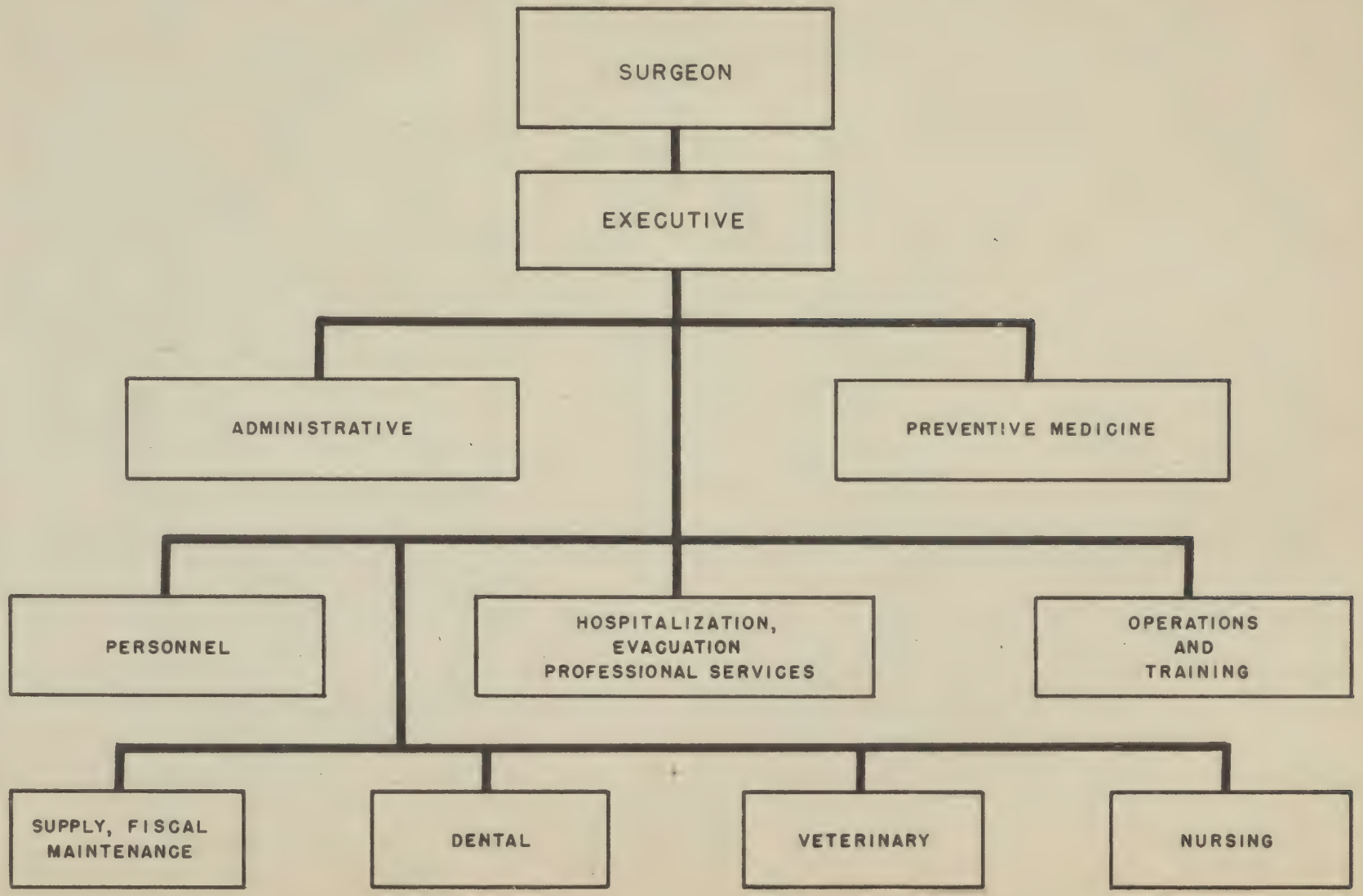
1300 - 1430	Army Hospitalization - Administrative and Operational Problems	
	Review of Hospitalization Program, including Hospitalization at Class III Installations.	Lt. Col. J. T. McGibony Col. W. F. Cook
	Administration of Fixed Hospitals in Zone of Interior.	Mr. R. E. Garrett
	Station Complement Functions at Class II Medical Installations.	Maj. R. Murray, Jr.
	Maintenance, Repair and Utilities in Hospitals	Mr. Frank Chedester
	Use of Hospital Funds.	Mr. F. A. McGillen
1430 - 1630	Personnel Problems	
	Use of Medical Department Specialists and Consultants.	Col. A. Freer Col. F. L. Cole, and Col. J. M. Caldwell
	Military Personnel, including Discussion of Central Officer's Assignment Group.	Col. F. P. Kintz
	Integration of Medical Department Officers into Regular Army and Army Interne Program.	Lt. Col. L. Smith
	Personnel Trends - Requirements and Availability of Personnel; Separation Criteria.	Mr. I. Cogan
	Medical Administrative Corps Situation.	Maj. B. Aabel
	Colored and White Male Enlisted Situation.	Maj. W. Wesche
	Women's Army Corps Situation.	Capt. B. I. Ringold
	Dental Personnel and Central Dental Laboratory Service.	Brig. Gen. T. L. Smith
	Nursing Problems.	Col. F. A. Blanchfield Lt. Col. I. W. Danielson Lt. Col. M. E. Aaron
	Dietetic Problems	Maj. H. C. Burns
	Civilian Personnel	Mr. C. R. Uphoff
1900 -	Reception and Dinner (Officers) - Officer's Club Army Medical Center	

TIME AND PLACE	TOPIC FOR DISCUSSION - ACTIVITY	DISCUSSION CHAIRMAN
19 July 1946 - Room 2E-809, The Pentagon		
0900 - 1130	Medical Department Training	
	Professional Graduate Training Program.	Col. R. E. Duke
	Status of Assignment of Medical Department Officers in Professional Graduate Training.	Col. H. E. Leech
	The Postwar ROTC.	Col. R. E. Duke
	General Reserve Units - Their Training and Utilization.	Lt. Col. L. F. Ferrell
	The Brooke Army Medical Center & The Medical Department Board.	Brig. Gen. J. M. Willis Lt. Col. V. D. Pettit
1130 - 1200	Medical Department Legislative Program - Current Status	Capt. E. R. Taylor
1200 - 1300	Lunch - Officer's Dining Room Lounge Corridor 10, 3rd Floor, between A and C Rings	
1300 - 1500	Preventive Medicine	
	Preventive Medicine Organization, Public Relations and Communicable Disease Control.	Col. T. F. Whayne
	Venereal Disease Control.	Maj. L. N. Altshuler
	Army Area Laboratories.	Lt. Col. R. L. Cavenaugh
	Sanitation and Sanitary Engineering.	Lt. Col. J. W. Regan
	Occupational Hygiene.	Maj. R. H. Duiguid
	Army Area Nutritionists.	Capt. R. C. Cogswell
1500 - 1600	Medical Supply Problems	
	Supply of Hospitals (Discussion of Proposed TM 38-220).	Col. S. B. Hays
	Hospital Equipment Modernization Program.	Col. S. B. Hays
1600 - 1630	Closing Session - Presentation and Discussion of Topics Presented by Conferees - Summary.	Brig. Gen. G.B. Denit

ORGANIZATION CHART

ARMY SURGEON'S OFFICE

UNDER WAR DEPARTMENT REORGANIZATION PLAN (PROPOSED)



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WAR DEPARTMENT
OFFICE OF THE SURGEON GENERAL
Washington 25, D. C.

SUBJECT: Civilian Expert Consultants

TO: Commanding Officer

1. A program for the graduate education of Medical Corps officers is being established in certain Medical Department installations under the provisions of W.D. Circular 101, dated 4 April 1946, and AR 350-1010, dated 11 February 1946. The scope of this training is broad, including Army internships, mixed residencies, residencies in medical and surgical specialties, post-graduate specialty training, and military medical research projects.

2. An augmentation of the professional staffs of those installations conducting such graduate training is being provided for by obtaining the services of well qualified civilian consultants. These consultants are being appointed by the Secretary of War, upon the recommendation of The Surgeon General. It will be advisable to have several consultants in each specialty, and local arrangements should be made to insure that each consultant has a specified tour of duty.

3. Commanding Officers will be furnished the names of the consultants by The Surgeon General's Office. It will be the responsibility of Commanding Officers to contact their respective consultants to make plans, arrange hours and schedules, to coordinate, and to integrate their services into the teaching program. They are to regard these consultants as members of their professional staff, and will utilize their services in whatever way they deem best to further this training program. It is to be understood that the primary function and duty of the civilian consultants thus appointed is teaching. However, they are also to be utilized to assist in the professional care of patients. It is desired that the consultants serve on a regular teaching schedule of one to three sessions per week, depending upon the needs of each particular service. Routinely, the consultants will be present during duty hours, but they should be available for emergency consultations. Consultants will be expected to maintain close liaison with chiefs of respective services in connection with all visits to the hospitals.

4. Consultants are to be paid for services rendered at the rate of $40 per day or fraction thereof. Payment will be made from funds available to your installation subject to the certification of availability by your fiscal officer. Approval of The Secretary of War will be forwarded to the Commanding Officer to be used as legal basis for issuing W.D. Form 50, Notification of Personnel Action, and for the certifying officer to pay for services rendered. No consultant may be used intermittently for more than 180 days, or for more than 90 consecutive days in any one fiscal year.

5. Under the provisions of the appointment, consultants are entitled to transportation, either public carrier, private automobile or government vehicle, and $6 per diem in lieu of subsistence while traveling and while on temporary duty away from their homes. Travel costs will be charged to funds available to your installation, subject to the certification of availability by your fiscal officer.

6. Authority is delegated to each Commanding Officer for developing detailed procedures for the consultants reporting for duty, and the recording of their visits.

BY COMMAND OF MAJOR GENERAL KIRK:

/s/
H. W. DOAN
Colonel, Medical Corps
Executive Officer

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WAR DEPARTMENT
Office of The Surgeon General
Washington 25, D. C.

SUBJECT: Expert Consultant Service and Travel

TO: Commanding General
_____Army

ATTENTION: Army Area Surgeon

1. The services of Dr. _____ ___. _____, _____, _____, _____, _____, who has been duly appointed a Civilian Expert Consultant to The Surgeon General under Section 8 of the Military Appropriations Act of 1947, are hereby made available to yourcommand on or about _____ _____, 1946, for approximately _____days. Attention is invited to WD Circular No. 101, 1946, Section III on Professional Consultants.

2. Travel orders, as necessary, calling him to duty and designating the itinerary, including Class II Installations, to be followed to accomplish the mission will be issued by you and be in the Expert Consultant's possession before the travel starts. Under the provisions of appointment, he is entitled to transportation, either public carrier, including by commercial or military aircraft, private automobile, or Government vehicle, and $6.00 per diem in lieu of subsistence while traveling and while on temporary duty away from his home. Travel costs will be charged to funds available to The Surgeon General under allotment number 701-1436 P432-02 A 2170425 S 49-007. This number will be quoted on all travel orders issued under this authority and a copy of each order will be forwarded immediately to this office, attention, Director, Fiscal Division. Travel between installations may be expedited if any necessary reservations are made in advance by your headquarters and Government car and driver is made available to the Expert Consultant where indicated.

3. Authority for the use of Expert Consultants must be obtained in advance for each tour of duty from the Office of The Surgeon General, either by telephone, wire, or letter. Inspection trips on weekends should be avoided as far as possible unless hospital key personnel concerned are notified in advance to be on duty. Hospital clerical personnel should be made available to the Expert Consultant, if he so desires, for typing his report.

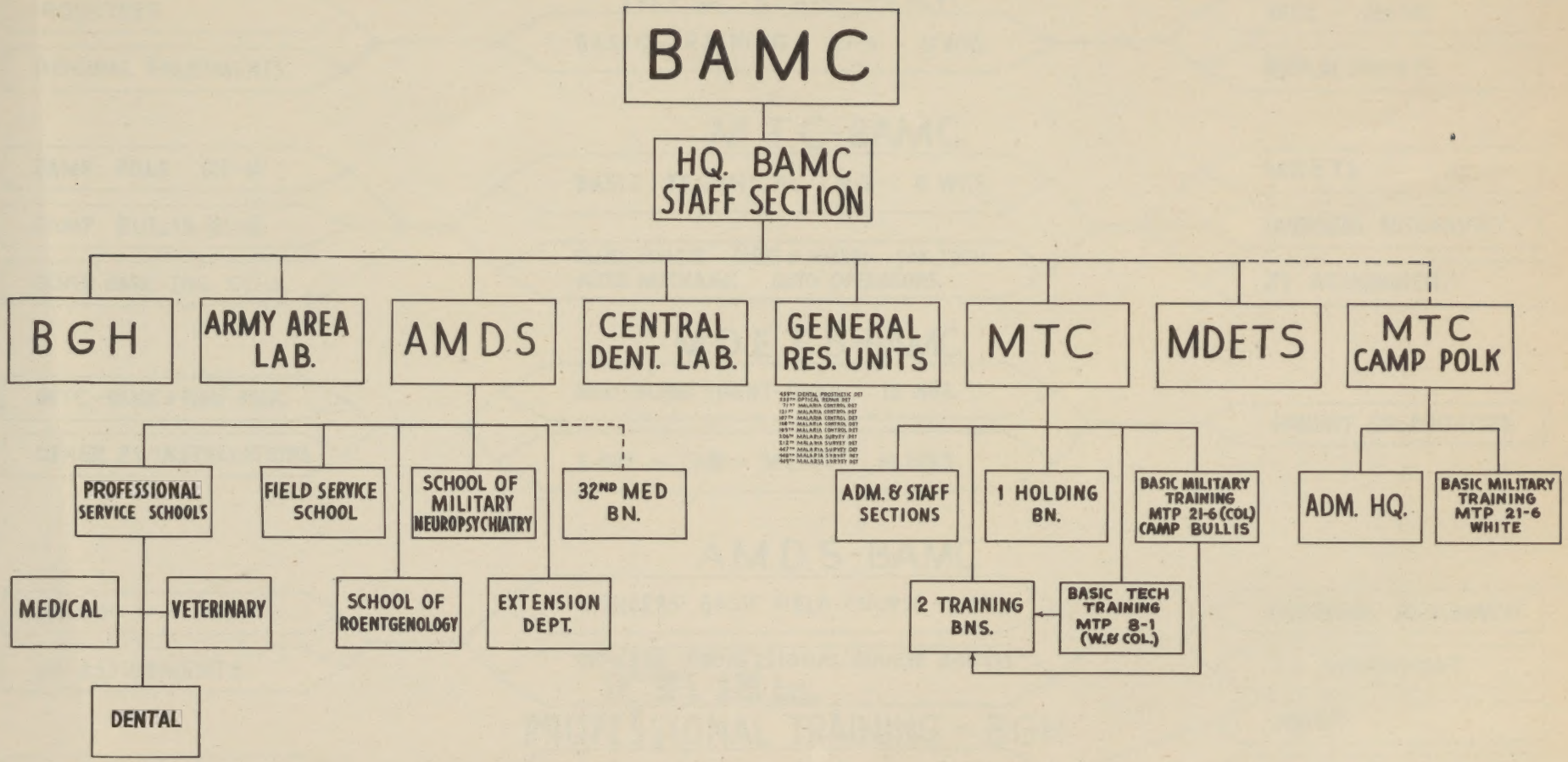
4. Your Army Headquarters' Adjutant should be informed of pending trips of Expert Consultants in order to avoid delay when the Expert Consultant reports to Headquarters for orders and the Army Area Surgeon is not available.

5. Collect telephone calls or telegraphic messages should be authorized for the Expert Consultant from his home to your Army Headquarters for instructions on his itinerary to avoid unnecessary travel to Headquarters.

6. In addition to travel expenses, Expert Consultants are to be paid for services rendered. After the services authorized above have been completed, submit a statement of services rendered along with Travel Voucher (Standard Form 1012), executed by traveler, to this office, attention, Chief, Civilian Personnel Service, for settlement.

FOR THE SURGEON GENERAL:

H. W. DOAN
Colonel, MC
Executive Officer


BAMC
HQ. BAMC STAFF SECTION
BGH
ARMY AREA LAB.
AMDS
CENTRAL DENT. LAB.
GENERAL RES. UNITS
MTC
MDETS
MTC CAMP POLK
PROFESSIONAL SERVICE SCHOOLS
FIELD SERVICE SCHOOL
SCHOOL OF MILITARY NEUROPSYCHIATRY
32ND MED BN.
MEDICAL
VETERINARY
DENTAL
SCHOOL OF ROENTGENOLOGY
EXTENSION DEPT.
ADM. & STAFF SECTIONS
1 HOLDING BN.
BASIC MILITARY TRAINING MTP 21-6 (COL) CAMP BULLIS
2 TRAINING BNS.
BASIC TECH TRAINING MTP 8-1 (W.& COL.)
ADM. HQ.
BASIC MILITARY TRAINING MTP 21-6 WHITE

TRAINING FLOW GRAPH BAMC